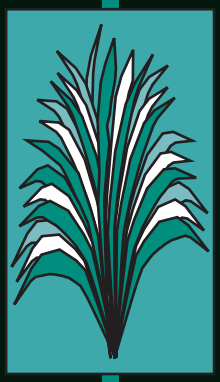
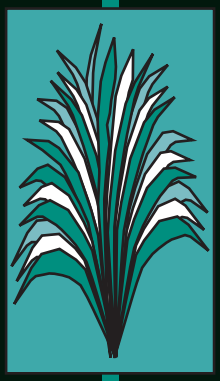





ACQUIRE Evaluation and Research Studies

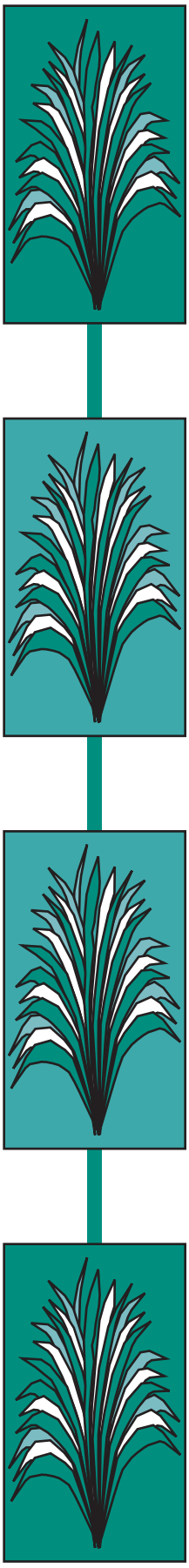
Improving the Use of Long-Term and Permanent Methods of Contraception in Guinea: A Performance Needs Assessment

E&R Study #1 ◆ May 2005

USAID FROM THE AMERICAN PEOPLE

the ACQUIRE project

ACQUIRE Evaluation and Research Studies



Improving the Use of Long-Term and Permanent Methods of Contraception in Guinea: A Performance Needs Assessment

E&R Study #1 ◆ May 2005

USAID FROM THE AMERICAN PEOPLE

the ACQUIRE project

c/o EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@acquireproject.org
www.acquireproject.org

This publication was made possible, in part, through support provided by the Office of Population and Reproductive Health, U.S. Agency for International Development (USAID), under the terms of cooperative agreement GPO-A-00-03-00006-00. The opinions expressed herein are those of the publisher and do not necessarily reflect the views of USAID.

The ACQUIRE Project (Access, Quality, and Use in Reproductive Health) is a collaborative project funded by USAID and managed by EngenderHealth, in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Meridian Group International, Inc., and the Society for Women and AIDS in Africa. The ACQUIRE Project's mandate is to advance and support reproductive health and family planning services, with a focus on facility-based and clinical care.

The performance needs assessment described in this publication was conducted in coordination with the PRISM Project (Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA), a USAID-funded collaborative project led by Management Sciences for Health.

Printed in the United States of America. Printed on recycled paper.

Suggested citation: The ACQUIRE Project. 2005. Improving the use of long-term and permanent methods of contraception in Guinea: A performance needs assessment. *E&R Study #1*. New York: The ACQUIRE Project/EngenderHealth.

Contents

Tables

Figures

Acknowledgments

The members of the assessment team (Dr. Levent Cagatay, Dr. Carmela Cordero, Wanda Jaskiewicz, Dr. Goma Onivogui, and Dr. Boubacar Touré) wish to thank all those who helped to facilitate this performance needs assessment to improve providers' performance and clients' and communities' access to and use of long-term and permanent methods of contraception (male and female sterilization, the IUD, and Norplant implants). We especially acknowledge all of the service providers and clients at the sites that we visited—Donka, Ignace Deen, and Ratoma Hospitals, Koulewondy Health Center, and the Association Guinéenne pour le Bien-être Familial (AGBEF) clinic in Conakry; Kankan Maternity, Salamani Health Center, and the Kankan AGBEF clinic, all in Kankan Region; and Faranah Maternity, Kissidougou Maternity, and Dabola Maternity and Abattoir, Madina, and Dabola Health Centers in Faranah. We also thank the Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA (PRISM) Project regional coordinators in Kankan and Faranah, the executive director of AGBEF, the evaluation coordinator at Save the Children, and the chief of the Reproductive Health Division at the Ministry of Health.

Additionally, we are grateful to the following people for the valuable insights that they provided: Neil Woodruff and Dr. Mariama Ciré Bah (from the U.S. Agency for International Development/Guinea), Dr. Mahi Barry (Guinea Ministry of Health), Dr. Robert Sarah Tambalou (AGBEF), and Eléonore Rabelahasa (PRISM). By taking time out from their busy schedules, by allowing us access to service sites, and by sharing their perspectives, they contributed to the success of this report.

Additionally, we thank the following ACQUIRE Project and EngenderHealth staff who helped to review and prepare this report:

Guinea Office

- Moustapha Diallo, Guinea country program manager
- Ousmane Traoré, finance/administrative assistant
- Mamadou Sow, driver

New York Headquarters Office

- John M. Pile, senior technical advisor for family planning services and networks, the ACQUIRE Project, for his assistance in planning the evaluation, in preparing the evaluation tools, and in synthesizing the background documents
- Inés Escandón, research technical advisor, for synthesizing the background statistical presentation
- John M. Pile, Robert Rice, senior technical advisor for training, the ACQUIRE Project, and Hannah Searing, monitoring and evaluation director, the ACQUIRE Project, for reviewing the report prior to finalization
- Michael Klitsch, for editing the report, and Anna Kurica, for designing and typesetting the report

Map of Guinea

Source: Perry-Castañeda Library Map Collection. 2004. *Guinea (Political) 2002*. Austin, TX: University of Texas at Austin. Retrieved from http://www.lib.utexas.edu/maps/africa/guinea_pol02.pdf, November 2, 2004.

Executive Summary

Guinea's health indicators are among the worst in the world, with infant, child, and maternal mortality rates at unacceptably high levels, a weak health infrastructure, and a burgeoning HIV/AIDS crisis. Use of modern methods of family planning is low—4.2% of currently married women—though nearly one in three currently married women have expressed a need for family planning. Even though both access to and use of temporary family planning methods (the pill, injectables, and condoms) have increased in recent years, long-term and permanent methods of family planning (LTPMs), such as male and female sterilization and the intrauterine device (IUD), continue to be underutilized (prevalence, 0.5%). Further, only one in four currently married women who do not want more children are using a method of family planning.

From February 24 to March 9, 2004, the ACQUIRE Project,[1] in coordination with the PRISM Project,[2] worked with the Guinea Ministry of Health to conduct a performance needs assessment (PNA) of family planning and other health care providers in three regions of Guinea. Its purpose was to identify performance gaps or problems and determine the most appropriate interventions to improve providers' performance and clients' and communities' access to and use of LTPMs. Two meetings with stakeholders were held, 14 sites were visited, and 32 providers and 34 clients were interviewed.

Assessments were conducted from February 25 to March 5 at a convenience sample of 14 health facilities in the Conakry, Faranah, and Kankan regions. Data were gathered on each facility's infrastructure, its technical, administrative, and human resources, and its other capacities, and service statistics on numbers of family planning clients over a period of six months were compiled. In addition, two to three providers from each facility were interviewed about their knowledge of and attitudes toward family planning methods and their perceptions of their work environment. Clients also were interviewed at each facility.

This performance information, which provided a snapshot of the family planning situation among providers, clients, and sites, was then used by the stakeholders to begin discussing how to correct weak areas within the system. It is important to note, however, that while analyses of performance gaps were based on real, valid data collected in the field, these data were not derived from a rigorous, scientific process. The intention in using them was simply to provide a relative comparison of data, to give stakeholders an overall sense of where the performance gaps are and how large or small they are.

The actual performance data illustrated a clear unmet need for family planning in terms of both spacing and limiting births. Many clients wanted to wait a number of years before having more children, did not want any more children, or were not sure. Despite this fact, only half of the clients inter-

---

[1] The ACQUIRE Project (which stands for Access, Quality, and Use in Reproductive Health) is a five-year global cooperative agreement supported by the U.S. Agency for International Development (USAID) that is intended to advance and support the use of facility-based reproductive health and family planning services around the world. ACQUIRE is managed by EngenderHealth, in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Meridian Group International, Inc., and the Society for Women and AIDS in Africa.

[2] The PRISM Project (Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA) is a USAID-funded collaborative project led by Management Sciences for Health.

viewed reported ever having received information on family planning from a health care provider. What information they received mainly concerned temporary methods, and few were told about the IUD or about voluntary sterilization, even though many were potential users of LTPMs.

Reasons why clients do not learn more about LTPMs during consultations at the health facility include the following:

- Providers tended to focus the family planning information they give to the client on the method she asked about, without first discussing the woman's reproductive goals, learning more about her needs, and discussing how to address them.
- Health care providers missed opportunities for providing information on family planning in general. Very few postpartum and antenatal clients (15%) were told about family planning during their visit.

The reasons for the gaps in providers' giving information on LTPMs are systemic: Providers have good attitudes regarding LTPMs and in particular appreciate the IUD. However, they are not given clear expectations regarding their performance in providing information about LTPMs. Although providers report having received fairly frequent supervision visits, supervisors do not reinforce the need for providers to discuss with clients either their reproductive goals and current situation or to offer LTPMs as an effective method, when appropriate. Also, information, education, and communication (IEC) materials such as flipcharts, which are used to discuss family planning with clients, tend to provide more information on temporary methods, thus communicating to providers that this is where they should focus the client's attention. The environment in which providers work is not always conducive to helping them perform well: Most reported shortages of electricity and water and stock-outs of necessary supplies and materials.

Results from the PNA showed that actual performance among family planning service providers in relation to LTPMs is low, resulting in large performance gaps. Stakeholders identified the root causes for these gaps, prioritized these, and, based on their collective experience, brainstormed the following interventions for resolving the performance problems:

Client Level

- Conduct a community study to better understand opportunities for and barriers to use of family planning in general and LTPMs in particular
- Develop and implement a promotional campaign to increase clients' information regarding LTPMs—e.g., radio spots, educational talks, and support groups
- Train community health agents to provide information in the community regarding LTPMs

Provider Level

- Clarify job expectations for both family planning and other service providers in terms of LTPMs, via updated job descriptions, orientations, job aids, or supervisory feedback
- Update providers' knowledge of LTPMs—particularly female sterilization and vasectomy—to improve their information-sharing and counseling
- Update IEC materials to include more information regarding LTPMs
- Develop job aids to reinforce the family planning messages that providers should be giving
- Set and follow through on the expectation for conducting a weekly group educational talk on LTPMs in the health facilities

System Level

- Make family planning and LTPMs priorities for the Ministry of Health and have them communicate this message to lower levels
- Orient supervisors to give providers feedback on their family planning performance and to clarify expectations regarding providing clients with information on LTPMs
- Strengthen the management of logistics and supplies to prevent stock-outs of necessary materials and tools within each health facility

Improving the Use of Long-Term and Permanent Methods of Contraception in Guinea: A Performance Needs Assessment

E&R Study #1 ◆ May 2005

Background

From February 24 to March 9, 2004, the ACQUIRE Project, in coordination with the PRISM Project, worked with the Guinea Ministry of Health to conduct a performance needs assessment of family planning and other health care providers in three regions of Guinea. Its purpose was to identify performance gaps or problems and determine the most appropriate interventions to improve providers' performance and clients' and communities' access to and use of long-term and permanent methods of contraception (LTPMs)—specifically, male and female sterilization and the intrauterine device (IUD).

Context

Guinea's health indicators are among the worst in the world, with infant, child, and maternal mortality rates at unacceptably high levels, a weak health infrastructure, and a burgeoning HIV/AIDS crisis. To address these problems, the U.S. Agency for International Development (USAID) set the following strategic objectives for health and family planning in Guinea:

- To improve the quality of services at local health centers
- To mobilize communities to raise awareness about HIV/AIDS and other health issues
- To increase the sale of family planning and child health products through social marketing
- To develop a strategy to combat the spread of HIV in newly identified high-prevalence areas

Use of modern methods of family planning in Guinea is low—4.2% of currently married women—though nearly one in three currently married women (30.4%) have expressed a need for family planning.[1] In 2002, significant progress in the use of family planning was made, with a 40% increase in the number of couple-years of protection[2] achieved. More than 7 million condoms were sold, a 26% increase over 2001, and contraceptives can now be found not only at fixed sales points in 96% of Guinea's subregions, but also through a community-based distribution network and in health centers throughout the geographic region in which USAID supports family planning and reproductive health activities. Hand-in-hand with wider access, improvements have been made in the quality of family planning services in areas of Upper Guinea.

---

[1] Direction Nationale de la Statistique and Macro International, Inc. 1999. *Enquête Démographique et de Santé Guinée, 1999*. Conakry, Guinée, and Calverton, MD.

[2] Couple-years of protection (CYP) is an estimate of the protection provided by family planning services during a one-year period. It is based on the volume of all contraceptives sold or distributed free of charge to clients. CYP is calculated by multiplying or dividing the quantity of each method distributed to clients by a conversion factor. (The conversion factor is equal to the number of units needed to protect the couple for one year.)

Even though both access to and use of temporary family planning methods (the pill, injectables, and condoms) have increased in recent years, LTPMs continue to be underutilized (prevalence, 0.5%). Further, only one in four currently married women who do not want more children are using a method of family planning.[3]

Overview of the Performance Improvement Approach

The performance improvement approach is a systematic methodology for solving performance problems that hinder providers' ability to deliver high-quality, sustainable health services. The process is highly participatory in nature, involving a mix of in-country stakeholders at a number of administrative levels. In addition to fostering increased ownership of the performance improvement process, this multilevel participation is critical because the stakeholders are the people who can best comprehend the performance situation at hand: They know their health system and their communities and can best propose and act upon appropriate solutions.

One of the most important steps in the performance improvement approach is the performance needs assessment (PNA). A PNA compares desired performance to actual or current performance, to identify the performance gaps in a given area. Desired performance is determined by the stakeholders and represents the base performance expected of providers or a system. Actual performance may be evaluated by observing provider performance in a given area, interviewing providers, holding focus-group discussions or interviews with clients and nonclients, and conducting clinic record reviews. As part of the PNA, stakeholders review the performance gaps encountered and conduct root-cause analysis to identify the basic causes of the performance issues. They then identify and select the most appropriate interventions to address the root causes and thereby decrease the performance gaps (see Figure 1).

The PNA focuses on understanding the environment in which service providers work and how well the system supports them to do their work well. It is the role of the organization to support providers via supervision, communication, and policies. The performance improvement approach emphasizes the performance factors that the organization must have in place for service providers to perform well. These performance factors are:

- Clear job expectations
- Performance feedback
- Motivation
- Physical environment and tools
- The skills and knowledge needed to do the job

These factors provide useful information for determining the root causes of performance gaps and for effectively selecting interventions to implement.

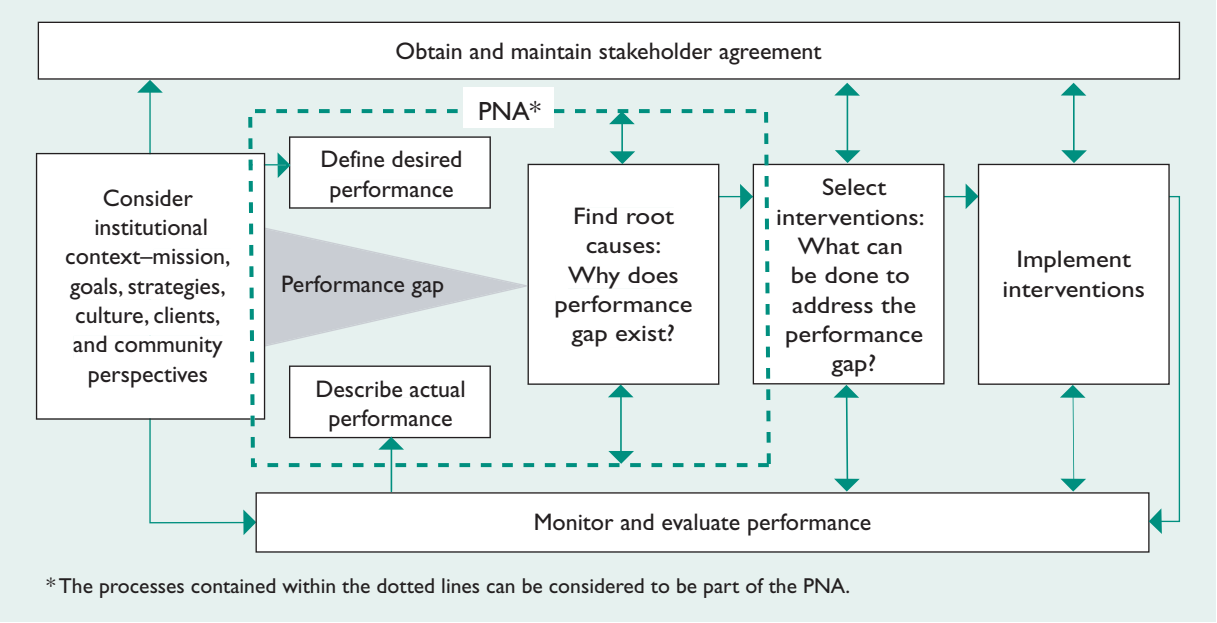
Key steps in the PNA include:

- **Stakeholders' agreement.** Before the PNA begins, the PNA team meets with stakeholders to identify desired performance for providers, understand their opinions regarding performance problems, and discuss the process to be followed during and after the assessment.

---

[3] Direction Nationale de la Statistique and Macro International, Inc. 1999. *Enquête Démographique et de Santé Guinée, 1999*. Conakry, Guinée, and Calverton, MD.

Figure 1. The Performance Needs Assessment (PNA) and Where It Fits into the Performance Improvement Framework



- **Data collection on actual performance.** The assessment is conducted using various methods, depending on the performance problem. Some assessment techniques include observing provider performance, interviewing providers, holding client exit interviews, conducting focus groups, performing site assessments, and reviewing clinic records.
- **Data analysis.** The collected data are then analyzed and a summary presentation of results (by instrument) is prepared to distribute to stakeholders.
- **Stakeholders' workshop to analyze root causes and select interventions.** Participants review results of data collection and, based on the desired performance statements developed earlier, they determine the performance gaps. The stakeholders analyze the root causes of the performance gaps and identify and select interventions appropriate for addressing the performance issues.

Purpose of the Performance Needs Assessment

The goal for conducting the Guinea PNA was to identify and select appropriate interventions that will improve the performance of family planning and other health providers to increase use of, access to, and quality of family planning services, particularly those related to LTPMs.

We accomplished the PNA by working with stakeholders from the central, regional, and prefectural levels of the Guinea Ministry of Health (MOH), from the Association Guinéenne pour le Bien-être Familial (AGBEF), from USAID, and from such collaborations and nongovernmental organizations as PRISM, Save the Children, and EngenderHealth. The geographic reach of the PNA conducted in Guinea extended to the Conakry, Faranah, and Kankan regions.

Defining Desired Performance

Defining desired performance is the first step to solving provider performance problems. The process continues to uncover how the system is supporting or impeding the work that providers do, to

determine how best to create an enabling environment in which providers can perform. A quote from the walls of the Faranah Hospital conference room best sums up this philosophy: *"Personne n'est en cause, l'accuse c'est l'organisation (la maniere de faire; le processus)"* (No one person is to blame, the fault lies with the organization [the way of working; the processes]).

On February 24, 2004, the ACQUIRE Project conducted a one-day meeting with stakeholders from the central-level MOH, three hospitals, AGBEF, USAID, PRISM, and EngenderHealth. The purpose of this meeting was to discuss family planning in Guinea, increase stakeholders' familiarity with the performance improvement approach, reach a consensus on the need to improve the utilization of LTPMs, and determine desired performance for family planning providers. (See Appendixes 1 and 2 for the agenda of this meeting and for a list of participants.)

The desired performance defined by stakeholders sets the standard level at which the providers are expected to perform. In working groups, the stakeholders discussed desired performance statements for family planning providers in relation to family planning in general and LTPMs in particular. The stakeholders then agreed in plenary session on the desired performance statements for providers. (See Table 1 for the list of desired performance statements.) These desired performance statements were also reviewed and agreed upon by stakeholders present at the second stakeholders' workshop, in Dabola on March 8 to 9, 2004. (See Appendixes 3 and 4 for the agenda of this meeting and for a list of participants.)

All mentions of family planning providers in the desired performance statements represent providers at the health facilities in which EngenderHealth is working (the project's geographic scope). Likewise, for Statements 2 to 4, which describe site-specific goals, the health facilities represent those in which the ACQUIRE Project will be working.

Assessment Sample Size and Methodology

Data collection was conducted from February 25 to March 5 at a convenience sample of representative health facilities in the Conakry, Faranah, and Kankan regions. Table 2 illustrates the numbers and types of facilities assessed, by region.

A number of approaches were used to collect information for the assessment. Table 3 (page 6) lists these and presents the sample size achieved for each. The site assessment, which was done once per facility, gathered data on the facility's infrastructure, its technical, administrative, and human resources, and its other capacities. The service statistics section compiled data on the number of new and repeat family planning clients,[4] by contraceptive method used, over a period of six months.

For the provider interviews, two to three providers were interviewed per health facility. Both providers who offer family planning services and providers of other services (for example, antenatal care) were interviewed, as well as facility directors and unit heads. The interview guide consisted of questions regarding performance factors and knowledge of and attitudes and values regarding family planning methods.

Client exit interviews were conducted with about two or three clients per facility (where possible). Family planning clients were preferred, but antenatal care and postpartum clients were interviewed as

[4] New clients are those who come for the first time for any type of contraceptive method, while repeat clients are contraceptive users who make a follow-up visit concerning their chosen method or who visit a facility for another method.

Table 1. Desired Performance Statements Agreed Upon by Stakeholders

No.	Desired Performance Statements
	According to norms and procedures:
1(a)	One hundred percent of family planning providers should provide clients with information about all family planning methods, at all levels of the health system.
1(b)	Sixty percent of family planning providers should provide clients with information about LTPMs (the IUD, female sterilization, and vasectomy), at all levels of the health system.
1(c)	Eighty percent of family planning providers should provide the LTPM chosen by the client, at all levels of the health system.
1(d)	All family planning providers should refer the client to the next level when they cannot provide the requested method.
2	At least 26 sites should offer the IUD to family planning clients by 2005.
3	At least 15 sites should offer female sterilization to family planning clients by 2006.
4	At 40% of health facilities, an educational talk on LTPMs should be held once per week.
5	At least 40% of health facilities should provide family planning services without stock-outs in equipment, supplies, materials, or management tools (log books, records, and statistics books) by 2006.
6	At least 60% of providers of essential obstetric care, emergency obstetric care, antenatal care, postpartum care, postabortion care, voluntary counseling and testing for HIV (VCT), sexually transmitted infection (STI) services, and infertility services should discuss family planning with their respective clients.

Table 2. Numbers and Types of Facilities Assessed, by Region

Region	Hospital*	Health Center**	Other	Total
Conakry	3 (Donka, Ignace Deen, Ratoma)	1 (Koulewondy)	1 (AGBEF)	5
Faranah	3 (Faranah Maternity, Kissidougou Maternity, Dabola Maternity)	3 (Abattoir, Madina, Dabola)	0	6
Kankan	1 (Kankan Maternity)	1 (Salamani)	1 (AGBEF)	3
Total	7	5	2	14

* The hospital is the biggest health structure in a prefecture or region. It has several units or departments, including a maternity department. A maternity hospital is basically the maternity department within the hospital structure. The minimum activity package of the maternity department of the prefectural or regional hospital includes all essential obstetric services (such as antenatal care, delivery, placenta removal, family planning [all methods], cesarean section, postabortion care, blood transfusion, parenteral injection of drugs, and anesthesia).

** The health center is the second stage of primary health care. Its minimum activity package includes antenatal care, delivery services, and family planning (both reversible and long-term methods). Some urban health centers do not perform deliveries, as those facilities are located close to a hospital with a maternity department.

Table 3. Data-Collection Instruments Used in Evaluation and Sample Size for Each

Instrument	Sample Size
Site assessment and service statistics	14
Provider interview	32
Client exit interview	34
Chart review	140
Provider observation guide	11

well. The interview guide collected information regarding the client's experience at the facility, satisfaction with services, history of family planning use, and family planning knowledge and attitudes.

In the chart review, at each facility the data collector requested a stack of family planning client records and chose at random 10 records from this stack. One checklist was applied per facility, and using this checklist evaluators assessed the records for completeness and quality.

Finally, providers' activities were directly observed and assessed by means of the provider observation guide. This guide assessed the interaction of a provider with a client and the tasks that a provider performed during the family planning consultation. The number of providers observed depended on the availability of family planning clients at the facility at that time.

It is important to remember that the data collected, while reflecting real and valid field experiences, were not derived from a rigorous, scientific process. They were used to to give stakeholders an overall sense of where the performance gaps are and how large or small they are.

The assessment team included Dr. Carmela Cordero, the ACQUIRE Project's Improved Provider Performance Team Leader; Wanda Jaskiewicz, the ACQUIRE Project's Senior Technical Advisor for Performance Improvement; Dr. Levent Cagatay, Program Associate/Medical with the ACQUIRE Project; Dr. Boubacar Touré, EngenderHealth's Program Officer for Guinea; and Dr. Goma Onivogui, Chief of the Family Planning Section, Reproductive Heath Division, Guinea MOH.

General Data Results

Client Data

A total of 34 clients were interviewed. (Not all clients answered all of the questions, however.) Clients were selected for interview from among those coming for family planning, antenatal care, and postpartum services. Postpartum clients included those who had just delivered and those coming in for their postpartum check-ups. Family planning clients made up 41% (14) of the clients, while antenatal care accounted for 26% (nine) of the clients and postpartum care for 32% (11). The median age of the clients interviewed was 27. One-quarter of clients were aged 10 to 19 (the youngest was 13), one-third were 20 to 29, and one-quarter were 30 to 39. Half of the clients had no schooling, while 32% had a seventh-grade education or higher.

The large majority (85%) of clients interviewed were married, and almost all (94%) had been pregnant. Of these women, six reported having ever had an abortion, three had had a miscarriage, and three had had a stillbirth. When asked if they would like to have more children, 68% (23) responded in the affirmative, 21% (seven) said "no," and 12% (four) said they did not know. Of those who wanted more children, 56% wanted one to three more children, 21% wanted four or five more, 9% wanted six or seven more, and 14% gave various other responses. Of women who wanted more children, 56% (13) wanted their next birth within two to four years, illustrating the need for birthspacing among a sizable proportion of women.

Table 4. Clients' Understanding of Family Planning Methods

Method	Can Define Method		Cannot Define Method		Total	
	No.	%	No.	%	No.	%
Pill	16	70	7	30	23	100
Injectable	20	77	6	23	26	100
Condom	22	79	6	21	28	100
IUD	8	35	**15**	**65**	23	100
Female sterilization	12	50	**12**	**50**	24	100
Vasectomy	2	9	**21**	**91**	23	100

Fewer than half of the women interviewed (44%, or 15) responded that they had ever used a family planning method. Of those who had used a method, 10 had used the pill, seven injectables, and one condoms. (Some clients had used more than one method.) When antenatal and postpartum clients were asked if they intended to use a family planning method after their baby is born, 75% (15 of 20) stated they would. Of these women, 53% (eight) intended to use injectables, 27% (four) the pill, and 20% (three) female sterilization. Thirteen percent (two) said they intended to begin using a method immediately or within six weeks, 13% intended to do so between six weeks and three months after delivery, 20% within three to six months after giving birth, and 53% after one to two years. All women were asked if they would consider female sterilization, and approximately three-quarters (73%, or 24 of 33 who answered the question) stated that they would. When asked if they thought their partner would consider vasectomy, 48% (14 of the 29 who replied) said he would not, while 41% (12 of 29) did not know if their partner would consider it.

About half (52%, or 17) of the clients reported having received information on family planning during this or a previous visit. Those who received information stated that they had been informed about multiple methods, including the pill (15 mentions), injectables (15 mentions), condoms (13 mentions), the IUD (12 mentions), female sterilization (nine mentions), and vasectomy (three mentions). Only 15% (three) of the 20 clients who had sought antenatal or postpartum care received information regarding family planning during their visit. On the day of their visit, just 15% (five of 33) of all clients interviewed had attended a group education talk at the health facility.

Clients were also asked about their understanding of different family planning methods, with understanding defined as either knowing what the method is or how to use it. Table 4 presents data on those who replied to the question regarding understanding of family planning methods. The majority of clients were much more familiar with temporary methods than with LTPMs. Only 35% (eight) of the women interviewed knew what the IUD is, while 50% (12) knew about female sterilization. Vasectomy was the least known method of all, with 91% of those who responded replying they just do not know what it is. The shaded area in Table 4 clearly indicates that substantial proportions of Guinean clients did not understand LTPMs.

After defining the method, clients were asked whether they approved or disapproved of each family planning method. As can be seen in Table 5 (page 9), the majority of clients approved of temporary methods such as pills, condoms, and injectables. Most, however, stated that they did not know

enough about LTPMs and so did not have an opinion. Although many clients said that they approved of female sterilization, a large number (10) did not know about this method. The shaded area in Table 5 demonstrates that many clients had not yet formed an opinion about LTPMs, since they had not received enough information about these methods. Thus, it can be hypothesized that with the provision of correct information, people could form positive opinions.

The clients rated providers and health facilities relatively highly on a number of quality indicators (presented in Table 6). Almost all clients received the information and services they wanted (94%), thought the staff were skillful (94%), and felt that the provider was easy to understand (97%). Of those clients who had questions to ask, 88% stated that the provider let them ask the questions, and among these, 93% said the providers responded to their questions satisfactorily.

Slightly fewer than half (41%) of the clients stated that there were areas in the facilities that needed improvement. Many of the suggestions for improvement had to do with making the facility cleaner. Other suggestions included ensuring more privacy, giving more support to providers, and providing electricity. Overall, clients were happy with the services they received, with 73% (24 of 33) stating they were very satisfied and 27% (nine of 33) responding as satisfied (not shown).

Provider Data

A total of 32 providers were interviewed. The majority (17) were midwives, while eight were physicians, four were assistant nurses, and three were nurses. The providers interviewed included six hospital or health center directors, four heads of maternity wards, three midwives in charge, and 15 staff whose duties included providing family planning, postabortion care, or antenatal care and assisting at deliveries. Most providers interviewed had been working for many years in the health services field, with an average of 18.7 years of service. Half reported that they had been working for 21 or more years in the health area. Providers had worked at their current health establishment for 8.6 years, on average, with almost half having worked there for five years or fewer and with 25% having worked there for six to 10 years.

As Figure 2 (page 10) illustrates, providers tend to discuss temporary family planning methods more often with their clients than they do LTPMs. Among the 31 who responded to this question, most talked about the pill (97%) and injectables (90%), while three-quarters talked about condoms (74%). Of the LTPMs, many providers discussed the IUD (77%), while female sterilization (52%) and vasectomy (19%) received less attention in client consultations.

In terms of methods actually *provided*, the difference between temporary methods and LTPMs was much greater. More than 80% of health care staff reported providing temporary methods in the last three months: condoms (90%), the pill (87%), and injectables (84%). Of the LTPMs, the IUD had the highest level of provision, with 52% reporting they provided the method in the last three months. While only small proportions provided female sterilization and vasectomy (16% and 0%), this is due in part to the fact that only physicians are able to provide surgical methods. Four of the six physicians who reported having provided family planning services in the last three months stated that they had performed female sterilization in that period. In contrast, no physician reported having done a vasectomy in the past three months

When a method is not available, 22 providers (69%) stated that they refer the client to the next level. Other responses included that methods are always available (five mentions), that they recommended the client use another method while waiting for his or her method of choice (five mentions), and that they recommended another method (four mentions).

Table 5. Clients' Opinions of Family Planning Methods

Method	Approved		Disapproved		Did Not Know		Total	
	No.	%	No.	%	No.	%	No.	%
Pill	21	66	6	19	5	16	32	100
Injectable	21	62	8	24	5	15	34	100
Condom	19	70	8	30	0	0	27	100
IUD	5	19	6	22	**16**	**59**	27	100
Female sterilization	17	57	3	10	**10**	**33**	30	100
Vasectomy	3	10	4	13	**23**	**77**	30	100

Table 6. Clients' Assessment of Some Quality Indicators

Indicator	% Yes	% No or Do Not Know	N
Received information and services you wanted today	94	6	34
Think staff are skillful	94	6	34
Had questions you wanted to ask	50	50	32
If Yes, provider let you ask questions	88	12	16
If Yes, provider responded satisfactorily	93	7	14
Had enough privacy	82	18	28
Provider was easy to understand	97	3	30
Areas in facility needed improvement	41	59	34
Had specific appointment for visit today	74	26	31
Had to wait to be seen	19	81	32
Recommended friend to come here for services	97	3	34
Know of another place to get services	38	62	34
Told date for next appointment	97	3	34

Figure 2. Number of Providers Who Discussed and Provided Family Planning Methods

Overall, providers had generally favorable attitudes toward both temporary and permanent family planning methods. They spoke highly of LTPMs but felt that clients had reservations about them. For example, they stated that a lot of work needs to be done to sensitize men to vasectomy. Table 7 presents information collected regarding providers' attitudes toward different family planning methods.

Providers also had favorable attitudes toward integrating family planning with STI and HIV/AIDS services. Almost all (97%, or 31) providers stated that they provided information and counseling on STIs and HIV/AIDS to family planning clients. Ninety percent (29) responded that they would be willing to provide family planning services to an HIV-positive client, and 88% stated that they would be willing to provide family planning services to a person living with AIDS.

Providers tended to know about family planning in general, but may have given clients information only for the methods they asked about. Some providers followed old counseling principles in which they must tell a client about all family planning methods in great detail, even if the client has decided on the method she wants. At the opposite end of the spectrum, some providers did not ask clients any additional questions to understand the client's reproductive needs and desires, to help her make a more informed choice. Since few clients arrived seeking LTPMs, few providers gave information on these methods. Additionally, providers had not received clear job expectations about how they should perform, in regard either to family planning in general or to LTPMs in particular. Although information, education, and communication (IEC) materials generally included all methods, they tended to present more information on and dedicate more space to temporary methods. This can send providers the message that temporary methods should receive more attention.

With regard to voluntary surgical methods, providers tended to be less knowledgeable. Many providers stated that they did not know about female sterilization, while the majority claimed that they did not know about vasectomy.

Table 7. Providers' Attitudes toward Family Planning, by Method

Method	Attitudes
Pill	✦ Providers considered it a good method, but almost all said that people can forget to take it and so can fail. ✦ A few providers stated that the pill helps regulate menstruation and solve "women's health problems." ✦ Providers were divided on side effects: Some said they are minimal and temporary, while others stressed weight gain, nausea, and headaches. ✦ Many providers noted that it does not protect against HIV and other STIs.
Injectable	✦ Providers considered the injectable a good method, very well accepted, and discreet, but also noted that the method produces spotting and amenorrhea, and return of fertility is slow. ✦ Providers said that except when they are pregnant, women do not like not seeing their period, so amenorrhea is a problem. ✦ Providers noted that this method offers no protection against STIs. ✦ They considered it an advantage that there is no risk of forgetting to take the method.
Condom	✦ Providers thought that condoms are a very good method, and protect against STIs and HIV as well as against pregnancy. They are accessible, as they are sold everywhere. ✦ A few providers mentioned that condoms are good for adolescents. ✦ Six providers stated that you cannot feel or enjoy intercourse when using condoms. ✦ Two providers mentioned the possibility of breakage. (One said condoms can enter the uterus.)
IUD	✦ The majority of providers said that the IUD is "good, no risk of forgetting, long term, return of fertility is immediate." ✦ However, six providers believed that the IUD can move around in the body, that it can cause cancer, and that removal is difficult and can even kill. ✦ Many mentioned the need for monogamous relations, to protect against STIs.
Female sterilization	✦ Providers said that female sterilization is a very effective, permanent, irreversible method that is good for older women, women with grand multiparity, and/or women for whom another pregnancy would be risky. ✦ Many providers mentioned a lack of information about female sterilization and a need to raise people's awareness of the method. ✦ Providers also noted the difficulty that in the case of divorce and remarriage, a sterilized woman cannot have more children, and the husband will not like it if his wife cannot have children.
Vasectomy	✦ Many providers did not know about vasectomy, and it was seldom available. ✦ Others said that vasectomy will not be easy for men to accept, for religious and cultural barriers. Also, men believe that it produces impotence. ✦ Providers said there is a need for sensitization and change in behavior regarding this method, since people are slow in accepting it.

Performance-Factor Data

To assist in root-cause analysis, data were collected regarding how the organization supported providers and whether performance factors were present or absent. Providers were interviewed using a series of questions regarding the following subjects:

- Organizational support
- Job expectations
- Performance feedback
- Motivation
- Physical environment and tools
- Knowledge and skills

Organizational Support

In terms of organizational support, most providers stated that they have someone to turn to when they need support in different areas. With administrative questions, they went to the on-site supervisor or director (26 mentions), external supervisor (eight mentions), or a supply person (three mentions). When they needed medical supplies, they approached on-site supervisors or medical staff (13 mentions), an external supervisor (five mentions), or the pharmacy (two mentions). With clinical questions, they went to the on-site supervisor or other higher-level staff (25 mentions), referred to the hospital (five mentions), or asked a colleague (three mentions).

Almost all providers who were interviewed confirmed that they had received a supervisory visit in the last six months, with many having received more than one. Only 10% (three) had not had such a visit during this time period, while the rest had received one to two visits (45%) or three or more (45%). Providers stated that during these visits, the supervisors performed a combination of such tasks as the following:

- Observing providers on the job (24 mentions)
- Checking supplies (19 mentions)
- Performing administrative tasks (17 mentions)
- Attending clients (12 mentions)
- Checking cleanliness (two mentions)

A large majority of providers (88%, or 28 of 32) stated that they received performance reviews. Providers understood the purpose of the reviews to be to evaluate both their clinical and administrative skills (69%, or 22), to evaluate only their clinical skills (13% or four), or to evaluate only their administrative skills (3%, or one). Such reviews were conducted either both orally and in writing (61%, or 17) or just orally (39%, or 11).

Job Expectations

When providers were asked if they had a written job description, 63% (20) said they did. Of these, only about half (11) had the job description on hand and could show it to the interviewer. Regardless of whether they had a job description, all providers interviewed stated that they knew their family planning role. They claimed that they knew their role as a result of a combination of a verbal explanation by a supervisor or manager (16 mentions), training (16 mentions), a written job description (14 mentions), "part of the job/I just know" (seven), and learning on their own (two).

When asked what materials help guide them in doing their work, 25 providers mentioned multiple sources. The materials most mentioned were norms and procedures (by 14), flow charts (by eight), protocols (by seven), written instructions (by three), and job aids such as flipcharts and posters (also by three). Seven providers stated that they did not have any guidance materials for their use. Of the 25 providers who gave examples of materials, only 15 (60%) could show them to the interviewer at the time.

Performance Feedback

A large majority of providers (81%, or 26) said that in the last six months their supervisor had given them positive feedback for performing well. The frequency of the positive feedback varied, with 12 (46%) having received feedback one or two times in the last six months and with 13 having received feedback three or more times. Likewise, 21 providers (66%) stated that they had received feedback from their supervisor when he or she had not been satisfied with their work. In the last six months, this had happened one or two times to 67% of providers and three or more times to 14%. Of those who had received constructive feedback, all said they were able to use the information to do better in their job.

Motivation

Only half of the 32 providers (50%) stated that they had received *verbal* or *written* recognition in the last six months for doing their work well. Of those who responded affirmatively, the recognition came from such sources as their supervisor (14 mentions), clients (four mentions), the community (four mentions), and a colleague (one mention).

When asked if they received incentives from the MOH for good performance, 50% stated that they received nothing. Of those who said they had received things in return for good performance, the following were mentioned: training (six mentions), congratulations or recognition (five mentions), free or reduced-cost medicine and services (two mentions), uniforms (two mentions), a salary increase or bonus (two mentions), and equipment (two mentions). However, when asked if they received something from clients in return for doing their work well, all providers could mention one or more incentives, including respect (28), gifts (22), services in return (eight), money (eight), thanks (four), and recognition (three).

The majority of providers (63%, or 20) felt that they did not have opportunities for promotion for good performance or did not know if such opportunities existed. However, providers were almost unanimously aware of the consequences of poor performance (91%, or 29), including a verbal or written reprimand from a supervisor or from clients and the community (25 mentions), loss of clients (13 mentions), loss of responsibility (seven mentions), transfer to another unit (six mentions), loss of income or bonus (five mentions), and loss of job (three mentions).

Physical Environment and Tools

More than half of the 32 providers (59%) felt that their physical environment is not adequate for them to do their work. Likewise, 50% of the providers stated that they do not have a regular source of electricity in their health facility. Almost all (94%) believed that their clients have privacy, while 69% thought that their facility is comfortable for their clients and themselves. Sixty-nine percent of the providers did not believe that they have the equipment, instruments, and supplies necessary to do their job well. Examples of equipment and supplies that providers said they need included specula, forceps, delivery kits, tensionometers, gloves, instruments for procedures, IUD kits, stethoscopes, antiseptics, scissors, sonogram, uterine sounds, family planning forms, gowns, exam tables, mat-

tresses, a register, a cesarean section kit, contraceptives, and chlorine solution. Given this situation, 63% of providers (20) explained that clients have to bring their own supplies or buy them at the facility for use in their consultation.

Most providers (88%) felt that the time given them to do their tasks is practical and manageable. The others reported that they had to work overtime. Finally, 78% of providers (25) were satisfied with the organization of services at their facility.

Knowledge and Skills

Of the 32 providers interviewed, 84% (27) claimed that they had received training in various areas of reproductive health and family planning over the last five years. Providers stated they had been trained in infection prevention (19 mentions), counseling (12 mentions), quality improvement (12 mentions), postabortion care or manual vacuum aspiration (11 mentions), general family planning (10 mentions), IUD insertion (10 mentions), male or female sterilization (nine mentions), contraceptive technology update (five mentions), and STIs, HIV, and AIDS (five mentions). Of the providers who had received training, 88% (24) stated that they had been able to use what they learned in their work. Those who had received training in male or female sterilization said they had had few opportunities to use their skills, since they had few or no clients.

When asked if they felt they had the knowledge and skills necessary to do their job, 72% stated that they did. However, almost all providers mentioned that they would like to learn more about IUD insertion and removal (nine mentions), female sterilization (seven mentions), vasectomy (seven mentions), refresher reproductive health and family planning and contraceptive technology update (six mentions), counseling (six mentions), and COPE® (a quality improvement process that stands for "client-oriented, provider-efficient" services) (four mentions).

Site-Level Data

An assessment of human resource capacity showed that eight of the 14 sites that were visited had obstetrician-gynecologists, while only three had general practitioners. Only the hospitals and the two AGBEF clinics had obstetrician-gynecologists on staff. All of the 14 health facilities had midwives, 64% had nurses, and half (seven) had assistant nurses. Four of the health centers, four hospitals, and the AGBEF Conakry clinic had nurses; the majority of these were located in the capital, Conakry. The facilities with assistant nurses were health centers and hospitals located outside the capital.

The health facilities offered family planning services from five to seven days per week. Outside the capital, health facilities tended to offer family planning services over the weekend, while in the capital these were offered only during the five days of the work week. Almost all of the facilities (13) had signs advertising family planning services, either both inside and outside the facility or only inside or outside the building. All facilities had some form of IEC materials about family planning. Almost all of the sites (13) used family planning flipcharts to give clients information. The majority of facilities had posters (11) or signs (eight) about family planning. Only five facilities had family planning brochures to distribute to clients. Health talks on family planning were held at almost all (12) of the facilities.

In regard to the physical environment, the exam room for family planning services generally had both visual and auditory privacy at all health facilities. In all cases, the exam room was clean, and in most it had an adequate light source (10) and an adequate water source (11).

Table 8. Available Equipment and Supplies

Item	% of Facilities with Availability (N=14)	Average Number Available
Blood pressure apparatus	71	1
Stethoscopes	79	1
Specula	79	3
Tenacula	64	2
Sponge/ring forceps	57	2
Uterine sounds	50	2
Scissors	57	1
Minilaparotomy kits	43	1
Vasectomy kits	0	0

Table 9. Facility Stock-Outs of Supplies and Contraceptives

Item	% of Facilities with Stock-Outs (N=14)
Gloves	43
Disinfectant	21
Syringes	14
Anesthetic drugs	18 (N=11)
Suture material	18 (N=11)
Combined pills	21
Progestin-only pills	29
Injectables	15 (N=13)
IUDs	8 (N=12)
Condoms	0

The health facilities tended to lack much of the necessary equipment, tools, and supplies for family planning service provision. When they did have these items, quantities often were insufficient. Table 8 illustrates the availability of various instruments and supplies in the health facilities and, where they were present, the average number available.

Some facilities reported stock-outs in the last three months of supplies needed for providing family planning and other services. Most commonly, facilities reported running out of gloves (43%) and disinfectant (21%) in the last three months (see Table 9). Likewise, some facilities reported stock-outs in contraceptive methods in the last six months. Approximately one-quarter of facilities had run out of combined pills (three) and progestin-only pills (four). None of the facilities had stock-outs of their condom supplies.

Table 10. Health Services Availability

Service	% of Facilities Providing Service (N=14)
Essential obstetric care	79
Emergency obstetric care	57
Antenatal care	86
Postpartum care	57
Postabortion care	43
Voluntary counseling and testing for HIV	29
Consultations for STIs	100
Family planning counseling	100
Consultations for infertility	79

In 86% of the health establishments visited, the family planning record card system was only partially organized. (Partially organized was defined as "the data are neither systematically organized in a particular order [i.e., alphabetically or chronologically] nor stored in a neat and organized manner.") Only eight of the facilities (57%) had a record keeping system for keeping track of family planning commodities, while almost all (12) stored their family planning commodities by expiration date. Twelve of 14 facilities kept a daily family planning activity register or log book, and nearly all (13) used a multiple card system to record client visits. All facilities sent their monthly family planning statistics reports to a supervisor or to a higher unit.

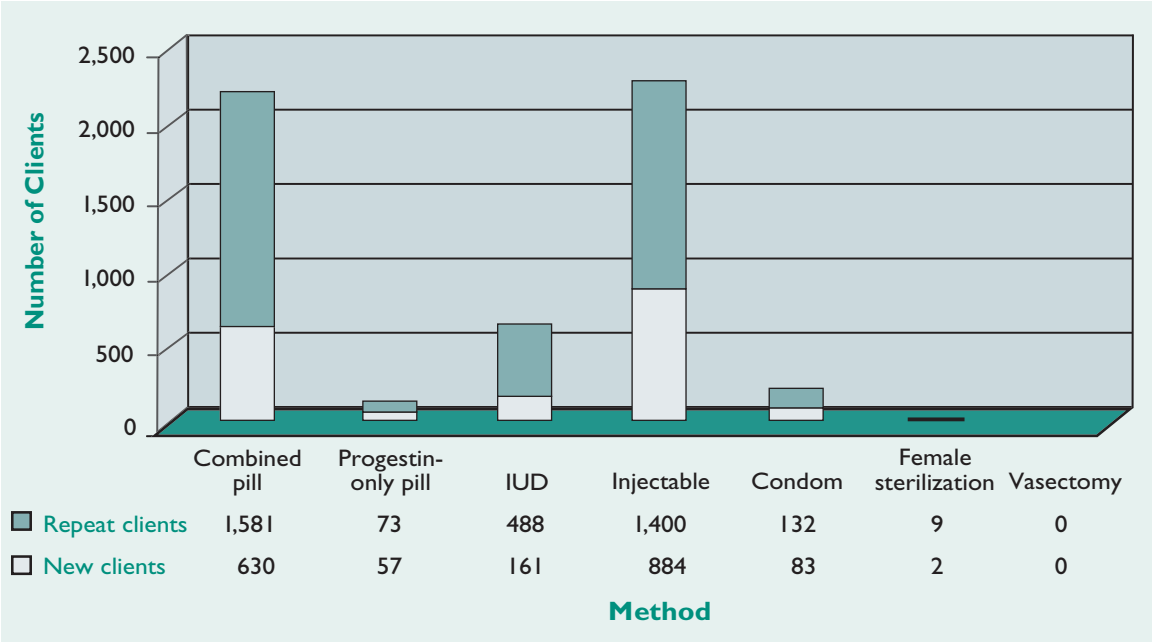
Finally, many health facilities provided a wide variety of reproductive health and other health services. Table 10 presents the proportion of facilities that provided care in specific areas. AGBEF clinics did not provide pregnancy-related services, and health centers did not provide emergency obstetric care. While health centers provided antenatal care, most did not provide postpartum services. Postabortion care was only provided at the hospital level. Voluntary counseling and testing for HIV was relatively new and only hospitals had begun providing it.

Service Statistics Data

When all health facility service statistics for July to December 2003 are considered together, the data show that temporary family planning methods were used the most (Figure 3). Of the total "new and repeat family planning clients" (6,793) for all facilities in this time period, temporary hormonal methods contributed the highest percentages: Thirty-four percent (2,341) used combined or progestin-only pills, and 34% (2,284) used injectables. The condom (3%, or 215) represented only a small percentage of family planning clients, since many of the facilities did not stock condoms and people tended to purchase condoms from pharmacies and other such sources.

Across all facilities together, the service statistics data for the six-month time period illustrate clients' low usage of LTPMs. IUD clients accounted for only 10% (649) of family planning clients, while female sterilization clients accounted for even fewer (only 11). At the bottom end of the scale was vasectomy, with no cases within the six-month time frame at all 14 facilities assessed.

Figure 3. Total New and Repeat Clients, by Family Planning Method, at All Health Facilities Combined (July to December 2003)



When the service statistics are broken down by type of facility, the two AGBEF clinics accounted for the majority of family planning clients for almost every method.[5] In terms of temporary methods, for example, the AGBEF clinics accounted for 51% (1,199) of new and repeat pill clients (users of both combined and progestin-only pills) across all 14 health facilities. Health centers served 35% (823) of pill clients, while hospitals saw only 14% (322). In the case of injectables, health centers served the highest percentage (55%, or 1,249) of all injectable clients, with AGBEF clinics and hospitals having served identical proportions of injectable clients (23% each—522 and 513, respectively). AGBEF condom clients represented 38% (82) of all condom clients at all facilities.

In regard to LTPMs, AGBEF had an even higher percentage of IUD users—72% (469) of the overall total of IUD clients across the 14 facilities. Hospitals served 27% (176) of IUD clients, while health centers had only four of the IUD clients. Of the 11 cases of female sterilization reported from July to December 2003, all took place at hospitals; health centers and AGBEF clinics do not offer surgical sterilization.

Client Record-Review Data

A random sample of 10 client records was reviewed at each health facility to check for accuracy and completeness in recording client data on record forms. Overall, the format of the client record form was not conducive to assisting women to use family planning methods. The form focused on identifying medical conditions and on finding problems, instead of on seeking to find what method would be best for a woman's situation. Also, the form did not ask specifically for the reason for a woman's visit—whether it was to seek a method, discuss complaints or side effects, or change a method. It

[5] It is not surprising that the two AGBEF facilities accounted for the majority of family planning clients. AGBEF is a national nongovernmental organization that focuses on family planning and has been in existence in Guinea since 1987. Its five clinics provide essentially family planning services, so most of their clients are people who are utilizing contraceptive methods. Facilities that also offer immunization services, antenatal care, and primary curative care tend to see fewer family planning clients in a typical day.

was assumed that the visit was just general family planning, as the form is for family planning only. However, in 35% of the records, providers recorded a more specific reason for the visit.

In general, providers had appropriately and completely filled out the data requested on the client record forms that they used in consultations. More than 90% of the records had completely registered the client's identification information, the date of the visit, and the prescriptions or treatment given (92%, 98%, and 97%, respectively). A large majority of the client charts had recorded medical history (88%), reproductive health history (86%), and follow-up plans (97%). Eighty-seven percent of the forms indicated that a general examination had been conducted and recorded. On only 44% of the family planning forms for repeat clients were the client's signs or symptoms recorded. In most cases, the space for side effects was blank, so one cannot know if clients had no side effects or if they were not asked. In other cases, the providers noted "none" in the space, to signify that they had assessed this item. Finally, 100% of the records reviewed were legible.

Determining Actual Performance

The actual performance data provide a snapshot of the family planning situation among providers, clients, and sites; this information is used by the stakeholders to begin discussing how to correct weak areas within the system. It is important to note that while the calculation of actual performance percentages is based on real and valid data collected in the field, this information is not derived from a rigorous, scientific process. The intention is to provide a relative comparison of data, to give stakeholders an overall sense of where the performance gaps are and how large or small they are. Large gaps are where priority attention needs to be focused, and small gaps are where the performance may be considered good enough. Using a quantitative measure like the percentage allows for easy understanding and visualization and for simple comparison of one performance gap against another.

With this in mind, actual performance percentages were determined using indicators from the overall data collected. Table 11 illustrates the actual performance percentages for each desired performance statement. (As a reminder, all mentions of family planning providers in these statements represent the providers working in the health facilities in which EngenderHealth is working—the project's geographic scope.) We determined the actual percentages for Statements 1(a) and 1(b) by assessing how many providers talk about all family planning methods to clients. (Only six of 32 providers interviewed [17%] talked about all methods, including the IUD, female sterilization, and vasectomy.) In relation to Statement 1(c), all health facilities have the capacity to offer at least the IUD (health centers and AGBEF clinics), while hospitals also have the capacity to offer permanent methods. Of the providers interviewed, 18 (56%) stated that they provide LTPMs (the IUD or female sterilization).

All facilities had working referral systems, and almost all providers (88%) stated that they refer clients to the next level when they cannot provide a particular method (Statement 1[d]). Likewise, for desired performance Statements 2 to 4, which described site-specific goals, the health facilities represented those in which the ACQUIRE Project will be working. The actual performance information for Statements 2 to 3 represents baseline project data for a number of sites in which ACQUIRE is working that already offer IUD and female sterilization services. Although educational talks on family planning were being held at the health facilities assessed, none included LTPM topics (Statement 4).

Since Statement 5 encompasses all materials and supplies needed to carry out family planning services, a stock-out in even one item that the site should have for its level means that the site does not meet the criteria for the statement and as such is marked "0." All health sites evaluated reported that

Table 11. Performance Gaps Identified through Comparison of Desired and Actual Performance

No.	Desired Performance Statements	Actual	Gap
	According to norms and procedures:		
1(a)	One hundred percent of family planning providers should provide clients with information about all family planning methods, at all levels of the health system.	17%	83%
1(b)	Sixty percent of family planning providers should provide clients with information about LTPMs (the IUD, female sterilization, and vasectomy), at all levels of the health system.	17%	72%
1(c)	Eighty percent of family planning providers should provide the LTPM chosen by the client, at all levels of the health system.	56%	30%
1(d)	All family planning providers should refer the client to the next level when they cannot provide the requested method.	88%	12%
2	At least 26 sites should offer the IUD to family planning clients by 2005.	13 sites	13 sites
3	At least 15 sites should offer female sterilization to family planning clients by 2006.	10 sites	5 sites
4	At 40% of health facilities, an educational talk on LTPMs should be held once per week.	0%	100%
5	At least 40% of health facilities should provide family planning services without stock-out in equipment, supplies, materials, or management tools (log books, records, and statistic books) by 2006.	0%	100%
6	At least 60% of providers of essential obstetric care, emergency obstetric care, antenatal care, postpartum care, postabortion care, VCT, STI services, and infertility services should discuss family planning with their respective clients.	15%	75%

they had experienced stock-outs in necessary family planning materials, supplies, and contraceptives. The health centers tended to lack more of the supplies and materials than did hospitals. Ignace Deen, Kankan, and Dabola hospitals, as well as the AGBEF clinic in Conakry, had the fewest items stocked out.

Finally, in relation to Statement 6, of the 34 clients interviewed, 20 had come for services other than family planning (antenatal and postpartum). Of these 20 clients, only three (15%) stated that they had received information on family planning during their consultation that day.

Calculating Performance Gaps

Performance gaps were determined for each performance statement, by simply subtracting the actual performance percentages from the desired performance and then dividing by the desired performance percentage (the goal). Doing this allows us to see how far away we are from the desired performance. For example, the gap for Statement 1(b) would be determined as following:

$$\frac{\text{Desired} - \text{Actual}}{\text{Desired}} = \frac{60\% - 17\%}{60\%} = 72\% \text{ (gap)}$$

The performance gaps are presented in Table 11. As the table demonstrates, the performance gaps vary in size. In some areas (e.g., Statement 1[c]), the gap is fairly small, while in others (Statements 1[a], 1[b], and 6), it is large.

Due to the number of performance gaps and limited resources and time for addressing them all, the stakeholders at the Dabola workshop were asked to prioritize these performance gaps. The criteria selected for judging each gap included the following:

- Importance of the performance gap
- Feasibility of addressing the gap
- Vulnerability (financial, human, and material resources)

Using these criteria, the stakeholders voted on the top five performance gaps on which to concentrate. These five gaps are shown as a darker shade of green in Table 11.

Analyzing Root Causes

For the prioritized performance gaps, stakeholders went through a root-cause analysis process, using the "multiple whys" technique, to analyze the basic reasons for why the performance gaps were occurring. This method consists of asking why a problem exists multiple times until all possible reasons have been exhausted and the most basic cause for the performance problem has been identified. The stakeholders divided themselves into four groups, with each group assigned a prioritized performance gap to analyze. (Performance Statements 1(b) and 1(c) were analyzed together, since they had originally been one statement. However, during the workshop, stakeholders suggested dividing the statement into two statements: one on giving information and one on providing the service.)

To aid them in the analysis process, stakeholders used the summary of data results presented earlier, including the performance factor assessment. For root causes identified, the groups classified them according to the related performance factor, for ease in identifying appropriate interventions in the next step. The root causes for each performance gap are illustrated in Table 12. The full decision trees for each group for their respective performance gap are presented in Appendix 5.

Stakeholders' Selection of Interventions

The final step in the PNA process, and the ultimate reason for conducting the PNA, is to select the most appropriate interventions that best address the identified root causes. Before brainstorming interventions for addressing the identified root causes, stakeholders developed criteria to be used for evaluating and selecting which of the brainstormed interventions they would put forward. The group identified the following intervention selection criteria:

- Financial resources
- Human resources
- Material and equipment resources
- Feasibility
- Efficacy
- Sustainability
- Acceptability by the target population

Table 12. Interventions Identified to Address Root Causes of Performance Gaps

Performance Gap	Root Cause	Intervention
Eighty-three percent of family planning providers do not provide clients with information about all family planning methods, at all levels of the health system.	Lack of coordination of training activities	1. Develop an annual operation plan that includes all activities of all partners at all levels. 2. Conduct periodic meetings of partners at all levels to share ideas and to reach agreement. 3. Revive the Training and Development Unit of the central MOH.
	Insufficient facilitative supervision	1. Solicit support from donors for supervision (financing, logistics, and techniques). 2. Train district health teams. 3. Train supervisors at central and regional levels. 4. Complete the organigram (Direction Régionale Santé/Direction Préfectoral de la Santé).
Forty-three percent of family planning providers do not offer clients information about LTPMs (the IUD, female sterilization, and vasectomy) at all levels of the health system. Twenty-four percent of family planning providers do not provide the LTPM chosen by the client, at all levels of the health system.	Weak promotion for LTPMs	1. Train providers in LTPM techniques. 2. Provide technical materials and equipment. 3. Sensitize the community about LTPMs via: • Local radio • Educational talks with: ❑ Women's groups ❑ Different social groups in villages ❑ Support groups for breastfeeding ❑ Peer educators, opinion leaders, and religious leaders ❑ Community health agents 4. Give community health agents information on LTPMs.
	Flipchart is incomplete and not available in all services	1. Update content and message in the family planning flipchart. 2. Produce and distribute flipcharts in sufficient quantities. 3. Reinforce facilitative supervision (clarify expectations) regarding providers' giving clients information about LTPMs. 4. Include in the scope of work of supervision that supervisors look at how providers give information to clients on LTPMs. 5. Conduct orientation sessions for providers on using the new flipchart.
Forty percent of health facilities do not provide family planning services without stock-outs in equipment, supplies, materials, or management tools (log books, records, and statistics books).	The availability of equipment, supplies, management tools, and contraceptives is not a performance factor for providers and decision makers.	1. Set up a mechanism to recognize good performance, including availability of materials and equipment at all levels. 2. Reinforce the monitoring and evaluation of logistical and inventory management. 3. Advocate for the mobilization of financial and material resources.
Forty-five percent of providers of essential obstetric care, emergency obstetric care, antenatal care, postpartum care, postabortion care, VCT, STI services, and infertility services do not discuss family planning with their respective clients.	Providers of services other than family planning do not consider it their job to discuss family planning with women during a consultation.	1. Advocate with authorities at all levels to integrate family planning within the minimum package of services. 2. Revise the training curriculum on contraceptive technology and counseling. 3. Revise supervision documentation (include information on family planning and LTPMs). 4. Train providers and supervisors in contraceptive technology and counseling. 5. Train supervisors in facilitative supervision. 6. Make IEC materials available within the health facilities. 7. Conduct supervision, monitoring, and evaluation.

- ✦ Acceptability by political, administrative, and religious authorities
- ✦ Congruence with the national political context

In their working groups, the stakeholders then brainstormed possible interventions to address the identified root causes behind the performance gaps. Table 12 presents the selected interventions by performance gap and root cause. The interventions address both the supply side and the demand side.

Conclusions and Recommendations

Client data demonstrate a clear unmet need for family planning, in terms of both spacing and limiting births. Many clients want to wait a number of years before having more children, do not want any more children, or are not sure. Despite this, only half of the clients interviewed reported having received information on family planning from the provider. This may also help explain why, given their need for family planning, fewer than half had used or were using a family planning method. And when they received information from providers, it mainly concerned temporary methods, with fewer mentions of IUDs or sterilization—even though many of the women were potential users of LTPMs.

Why did clients not learn more about LTPMs during consultations at the health facility? One reason is related to providers' approach to information-sharing and counseling. Providers tended to focus the family planning information they gave to a client on the method that she asked about, without first carrying on a discussion about her reproductive goals, to learn more about her needs and to discuss how to address them. Given that most women reported knowing or having heard about some temporary methods, it is reasonable that they would have arrived seeking a hormonal or barrier method. Interestingly, of the 10 women who stated that they did not want more children or did not know, all claimed that they would consider female sterilization. However, only three of these women received any information regarding this method. Had providers asked more questions, they could have better directed their information. Another reason for the lack of information is that while group talks at the health facility included discussions of family planning, they did not incorporate information on LTPMs.

Additionally, providers missed opportunities to offer general information on family planning. Providers of services other than family planning, such as antenatal and postpartum care, had an opportunity to spread messages about family planning, its benefits, and how to find out more. Yet the data show that only 15% of antenatal and postpartum clients were told about family planning during their visit.

The reasons for the gaps in providers' information-sharing about LTPMs are systemic rather than individual. Providers have good attitudes regarding LTPMs and in particular appreciate the IUD. However, providers of both family planning and of other services were not given clear expectations regarding their performance in offering information about LTPMs. Although providers reported receiving fairly frequent supervisory visits, supervisors did not reinforce the need to discuss clients' reproductive goals and current situation or to offer LTPMs as effective methods, when appropriate. Likewise, only half of the providers interviewed had a written job description, although in general, job descriptions do not give explicit performance expectations about LTPMs. Finally, IEC materials such as flipcharts, which are used to discuss family planning with clients, tended to provide more information on temporary family planning methods, communicating to providers that this is where they should focus the client's attention.

Providers were knowledgeable about family planning in general but felt less sure about either male or female sterilization. Many reported that they had received training in reproductive health and family planning in the recent past, yet due to few client requests for information on LTPMs, providers may not have had much practice in information-sharing or counseling on these methods. Of those who were able to provide sterilization services, very few had had an opportunity to utilize these skills, since few clients sought female sterilization and none sought vasectomy. Many providers expressed interest in learning more about LTPMs. Additionally, providers did not have sufficient job aids or other reference materials, such as norms or protocols, to guide them in their family planning work.

Another cause of low provider performance may have been a lack of motivation. Only half of providers had received recognition for good performance in the past six months. The same proportion stated that they received no incentives from the MOH in return for a job well done. However, all providers stated that they receive incentives from their clients. Interestingly, all providers were very aware of the consequences of poor performance, illustrating that there are disincentives for doing poor work but few incentives for doing good work.

The environment in which providers worked was not always conducive to helping them perform well: Most reported shortages of electricity and water and stock-outs of necessary supplies and materials. Over the past three to six months, each facility had run out of either contraceptives, family planning records, log books, gloves, or other tools necessary for the provision of family planning services.

To improve the utilization of LTPMs, based on input from the stakeholders' workshop and subsequent analysis of the data, we recommend the following approaches aimed at clients, providers, and the system in Guinea:

Client Level

- Conduct a community study to better understand opportunities for and barriers to use of family planning in general and LTPMs in particular
- Develop and implement a promotional campaign to increase clients' information regarding LTPMs—e.g., radio spots, educational talks, and support groups
- Train community health agents to provide information in the community regarding LTPMs

Provider Level

- Clarify job expectations for both family planning and other service providers in terms of LTPMs, via updated job descriptions, orientations, job aids, or supervisory feedback
- Update providers' knowledge of LTPMs—particularly female sterilization and vasectomy—to improve information-sharing and counseling
- Update IEC materials to include more information regarding LTPMs
- Develop job aids to reinforce the family planning messages that providers should be giving
- Set and follow through on the expectation to conduct a weekly group educational talk on LTPMs in the health facilities

System Level

- Make family planning and LTPMs priorities for the MOH and have them communicate this message to lower levels

- Orient supervisors to give providers feedback on their family planning performance and to clarify expectations regarding providing clients with information on LTPMs
- Strengthen the management of logistics and supplies to prevent stock-outs of necessary materials and tools within each health facility

Appendixes

Appendix 1

Agenda for February 24
Stakeholders' Agreement Workshop in Conakry

Stakeholders' Agreement Workshop Agenda
Conakry, Guinea ✦ February 24, 2004

Time	Activity
10:00 a.m.	Opening remarks by Dr. Mohamed Sidatty Keita (Chef Division, Santé de la Reproduction) ✦ Introduction to meeting ✦ Meeting purpose ✦ Today's agenda ✦ Introductions
10:30 a.m.	Review of reproductive health indicators in Guinea
11:00 a.m.	Questions for reflection
11:30 a.m.	*Break*
11:45 a.m.	Overview of the performance improvement approach ✦ COPE and performance improvement
12:30 p.m.	*Lunch*
1:15 p.m.	Desired performance of family planning service providers
2:30 p.m.	Closing remarks by Dr. Sidatty Keita

Appendix 2

February 24 Workshop Participants

Name	Position	Organization
Dr. Nagnouma Sano	Point focal, Santé de la Reproduction/Direction Nationale des Pharmacies et Laboratoires	Ministère de la Santé Publique (MOH)
Dr. Robert Sarah Tambalou	Director Exécutive	Association Guinéenne pour le Bien-être Familial (AGBEF)
Dr. Mohamed Sidatty Keita	Chef Division, Santé de la Reproduction	MOH
Dr. Eléonore Rabelahasa	Conseillère, Santé de la Reproduction/Qualité des Soins	Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA (PRISM)
Dr. Aminata Kaba	Chef, service Maternité	Centre Médical de la Commune de Ratoma
Dr. Mariama Ciré Bah	Chargée de Programme	U.S. Agency for International Development (USAID)/Guinea
Dr. Goma Onivogui	Chef Section, Santé Maternelle et Infantile/Planning Familial	Division Santé de la Reproduction/MOH
Dr. Carmela Cordero	Improved Provider Performance Team Leader	The ACQUIRE Project/ EngenderHealth
Ms. Wanda Jaskiewicz	Senior Technical Advisor for Performance Improvement	The ACQUIRE Project/ EngenderHealth
Dr. Sita Millimono	Chargée de Planning Familial	Centre Hospitalier Universitaire de Donka/Maternité
Dr. Levent Cagatay	Program Associate/Medical	The ACQUIRE Project/ EngenderHealth
Mr. Moustapha Diallo	Program Manager	EngenderHealth/Guinea
Dr. Boubacar Touré	Program Officer	EngenderHealth/Guinea

Appendix 3

Agenda for March 8 to 9 Stakeholders' Root-Cause Analysis Workshop in Dabola

Stakeholders' Root-Cause Analysis Workshop Agenda
Dabola, Guinea ✦ March 8 to 9, 2004

Objectives

- To review mission objective and performance improvement approach process
- To present desired performance
- To share and discuss results of estimation of performance in long-term and permanent family planning methods
- To determine performance gaps and identify root causes of performance gaps
- To identify and select interventions
- To discuss next steps

DAY 1: March 8, 2004

Time	Activity	Person Responsible
8:30–9:30 a.m.	Opening remarks by Directeur Préfectoral de la Santé, Ministère de la Santé Publique	Dr. Yamoussa Yattara
	✦ Introduction to meeting	
	✦ Introductions of participants and facilitators	Mr. Moustapha Diallo
	✦ Activity goal and meeting purpose	
	✦ Today's agenda	
	✦ Administrative information	
9:30–10:30 a.m.	Introduction to performance improvement	Ms. Wanda Jaskiewicz
	✦ Results of February 24 Stakeholders' Workshop and desired performance	Dr. Carmela Cordero
10:30–10:45 a.m.	*Morning break*	
10:45–11:45 a.m.	Results of data collection	Dr. Goma Onivogui
11:45 a.m.–12:30 p.m.	Actual performance	Dr. Boubacar Touré
12:30–1:30 p.m.	*Lunch break*	

continued

DAY 1: March 8, 2004 (continued)		
Time	**Activity**	**Person Responsible**
1:30–2:00 p.m.	Gaps in performance	Ms. Wanda Jaskiewicz
2:00–2:30 p.m.	Root-cause analysis	
2:30–3:30 p.m.	Group work on root-cause analysis	Participants
3:30–3:45 p.m.	*Afternoon break*	
3:45–4:45 p.m.	Group presentation	Participants; Dr. Eléonore Rabelahasa
4:45–5:00 p.m.	Wrap-up of Day 1	Participants

DAY 2: March 9, 2004		
Time	**Activity**	**Person Responsible**
8:30–8:45 a.m.	Review of Day 1	Mr. Moustapha Diallo
8:45–9:00 a.m.	Intervention selection	Ms. Wanda Jaskiewicz
9:00–10:00 a.m.	Group work on intervention selection	Participants
10:00–10:15 a.m.	*Morning break*	
10:15–11:30 a.m.	Group presentation	Participants
11:30 a.m.–12:00 p.m.	Next steps	Mr. Moustapha Diallo
12:00–12:15 p.m.	Closing remarks	Chef Division, Santé de la Reproduction
12:15	*Lunch*	

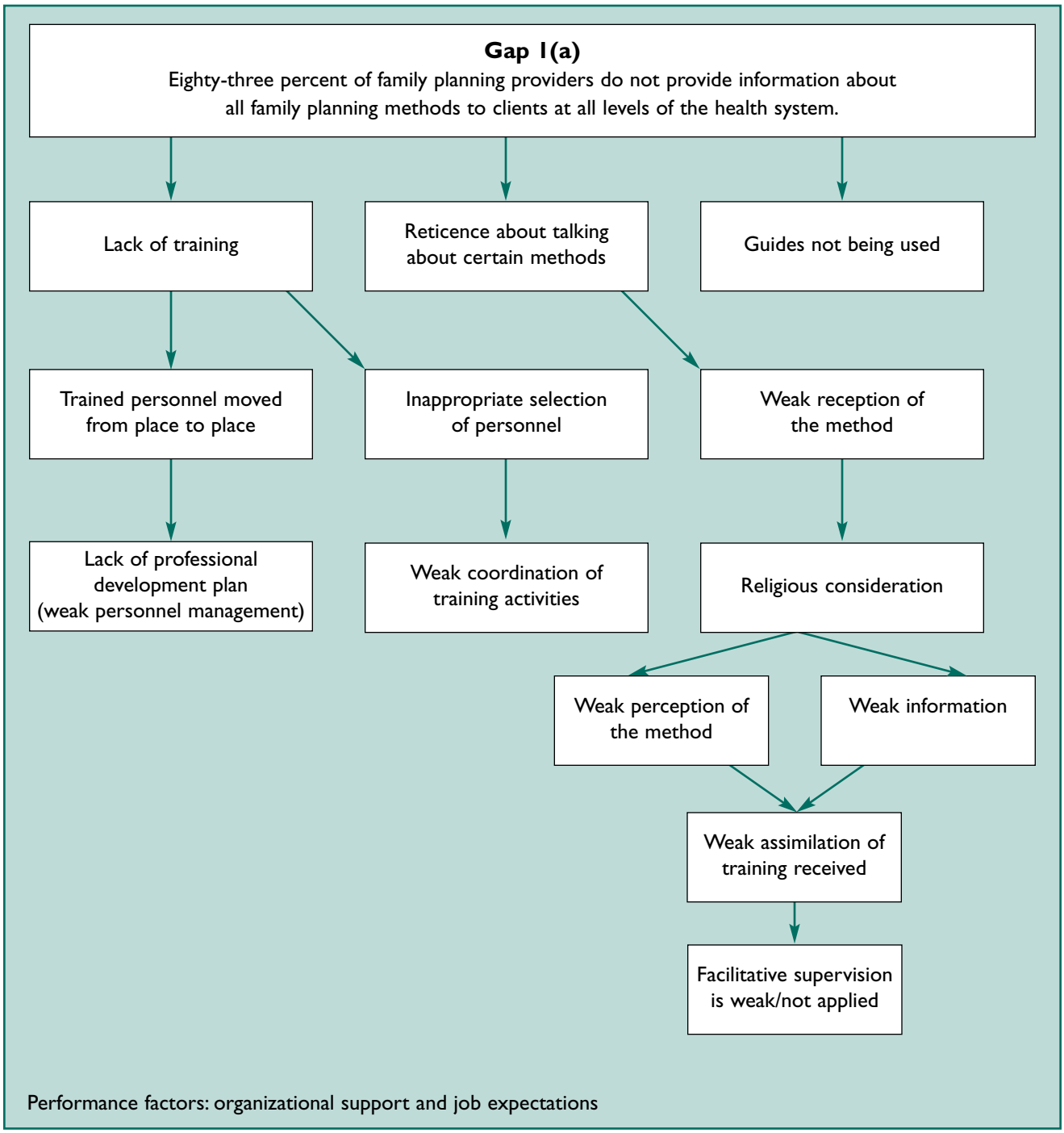
Appendix 4

March 8 to 9 Workshop Participants

Name	Position	Organization
Dr. Jean Kotou Koivogui	Chef, service Maternité	Hôpital Faranah
Dr. Mamady Souare	Chef, service Maternité	Hôpital Kankan
Dr. Aminata Kaba	Chef, service Maternité	Centre Médical de la Commune de Ratoma
Dr. Nagnouma Sano	Point focal, Santé de la Reproduction/Direction Nationale des Pharmacies et Laboratoires	Ministère de la Santé Publique (MOH)
Dr. Fatoumata Toure Konate	Inspection Régionale de Conakry	Direction de la Santé de la Ville de Conakry
Dr. Diallo Mamadou Oury	Coordinateur Suivi Evaluation	Save the Children
Dr. Ibrahima Camara	Direction Régionale Santé (DRS)-Pharmacie-Laboratoire	DRS/Kankan
Mr. Sekou Traore	Coordinateur	Association Guinéenne pour le Bien-être Familial (AGBEF)/ Kankan
Dr. Mabintou Camara	Chef Unité Planification Familiale, Soins après Avortement	Hôpital Ignace Deen
Dr. Bocar Dem	Coordinateur Régional	Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA (PRISM)/Kankan
Dr. Sita Millimono	Chargée, Planning Familial	Centre Hospitalier Universitaire de Donka/Maternité
Dr. Yamoussa Yattara	Directeur Préfectoral de la Santé	Dabola
Dr. Mohamed Cisse	Coordinateur Regional IEC	PRISM/Faranah
Dr. Mamadouba Camara	Maternité Dabola	Dabola
Dr. Mariama Ciré Bah	Chargée de Programme	U.S. Agency for International Development (USAID)/Guinea
Dr. Eléonore Rabelahasa	Conseillère, Santé de la Reproduction/Qualité des Soins	PRISM
Dr. Mickiry Camara	Médecin Chargé de la Maladie	Faranah

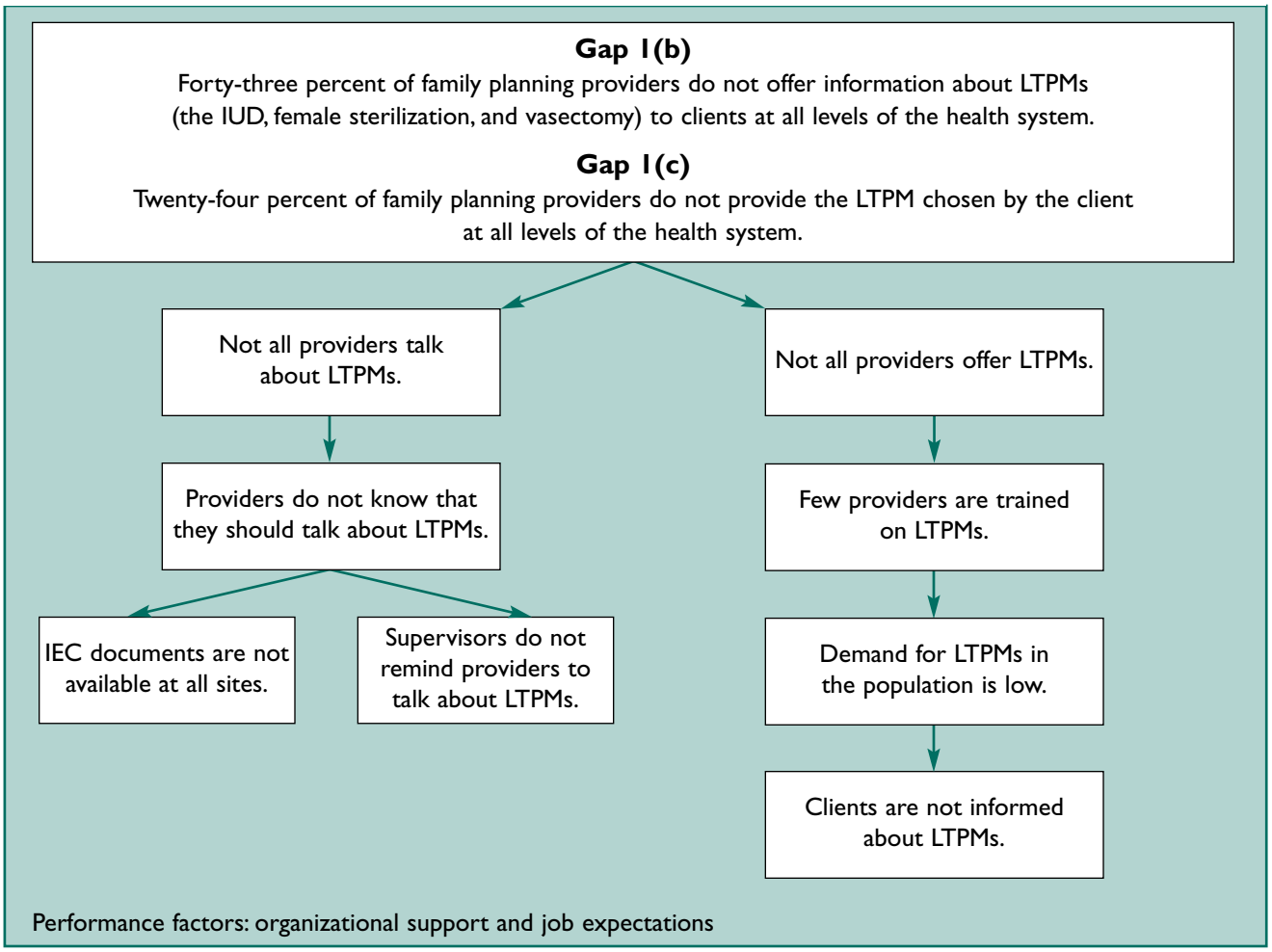
Appendix 5

Root-Cause Analysis Decision Trees



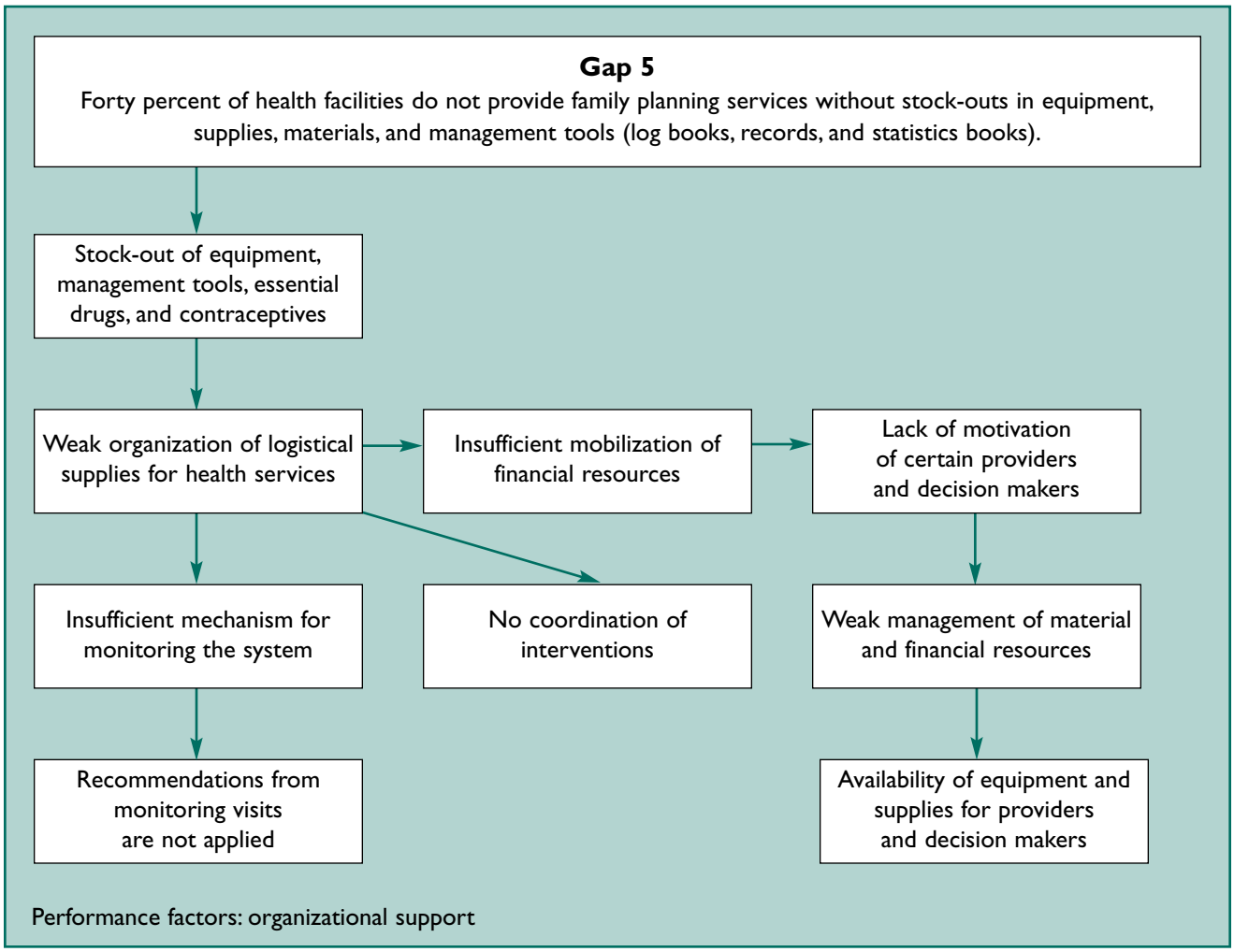
continued

Root-Cause Analysis Decision Trees (continued)



continued

Root Cause Analysis Decision Trees (continued)



Gap 6

Forty-five percent of providers of essential obstetric care, emergency obstetric care, antenatal care, postpartum care, postabortion care, VCT, STI services, and infertility services do not discuss family planning with their respective clients.

Causes

1. Providers do not know that they should talk about family planning with clients.
2. Providers do not have the knowledge or skills to talk about family planning.
3. Providers have not been trained.
4. Family planning is not integrated into the minimum package of activities.
5. Family planning services are selectively distributed around the country.
6. Certain services are given more priority than others.
7. Providers of services other than family planning do not consider it their job to discuss family planning with women during a consultation.

Appendix 6

Final Data Collection Tools Used in This Analysis

Provider Performance and Attitudes Interview

General Information

Health facility (name): _____

Type of facility:

___ Regional hospital ___ District hospital ___ Health center ___ Maternity clinic ___ NGO clinic

Region: _____

Date (dd/mm/yy): ____/____/____ Start time: _____ a.m./p.m.

Name of interviewer: _____

Instructions to the interviewer: Providers should be interviewed individually and in private when the provider can be available. It should be clear that you are seeking information on factors related to their working environment, and attitudes and practices, and are not evaluating the performance of the facility or of the providers individually. For each item, please answer each question by describing as appropriate or circling the correct response. General instructions to be read are in **bold** and specific instructions for each question are in *italics*.

Read this greeting to the interviewee and answer the questions below:

My name is _____ , and I am participating in a study to improve the quality of and access to long-acting hormonal and permanent family planning methods for EngenderHealth. To realize this goal, we need information on the attitudes and practices of facility providers, and have therefore invited you for this interview.

The interview will take about 60 minutes. The interview is strictly confidential, and nothing you say will affect your work at this facility. Your name will not appear in any of the interviews or in the materials that we will present in order to improve the quality of care.

No one will charge you for your participation in this study nor will you be paid. Your participation is completely voluntary, and if you decide to accept, only respond to those questions that you wish to answer.

Do you have any questions? (*If Yes*, note the questions.)

Yes _____ No _____

_____

_____

Would you like to participate in the study?

Yes _____ No _____

continued

- If the provider agrees to continue, ask if he or she has any questions. Respond to questions as appropriate, and then begin the questionnaire by asking Q. 1.0
- If the provider does not agree to continue, circle "refused interview," and if possible, provide a reason why the interview was refused. Thank him or her for his or her time, and go to the next interview.

Interview completed: 1 = Yes, complete 2 = No, incomplete 3 = Refused interview

If interview refused (give reason):

_____

_____

_____

*Be sure to return **here** at the end of the interview to indicate whether the survey was completed.*

Section 1. Performance Factors

1. Health Provider Details

1.0	What is your qualification?	Doctor	Midwife	Nurse	Assistant nurse	Other *(specify)*
		1	2	3	4	5 _____
1.1	What is your position and the department in which you work?					
1.2	Within your job duties, do you provide family planning services?	Yes	No	Don't know		
		1	0	88		
1.3	How long have you worked in the health services?	_____ years _____ months				
1.4	How long have you been working at this facility?	_____ years _____ months				

2. Job Expectations

2.0	Do you have a written job description?	Yes	No	Don't know	**If No or DK, skip to Q. 2.2.**
		1	0	88	
2.1	*If Yes*, can you show it to me?	1	0	88	
2.2	Do you know/understand what roles and tasks you have to carry out in the area of **family planning**?	1	0	88	**If No or DK, skip to Q. 2.4.**
2.3	How do you know what your roles and tasks in **family planning** are?				
	Through a written job description	1	*Interviewer: Do not prompt. More than one answer is allowed.*		
	Through verbal explanation by the manager or other person	2			
	From training or other external instruction	3			
	I learned on my own	4			
	Other *(specify)*:	5			
2.4a	Do you have any norms and procedures, flowcharts, or protocols assisting you to implement your family planning tasks?	Yes	No	Don't know	**If No or DK, skip to Q. 3.0.**
		1	0	88	*Interviewer: Mark the materials you were shown.*
2.4b	*If Yes*, can you show them to me?	Yes	No	Don't know	
	Norms and procedures	1	0	88	Yes No
	Flowcharts	2	0	88	Yes No
	Protocols (i.e., algorithm)	3	0	88	Yes No
	Other *(specify)*:	4	0	88	Yes No
	Other *(specify)*:	5	0	88	Yes No

3. Motivation/Incentives

3.0	In the last six months, have you received **verbal** or **written** recognition for doing your work well?	Yes	No	Don't know	**If No or DK, skip to Q. 3.2.**
		1	0	88	
3.1	*If Yes*, from whom have you received it?				
	Employer/supervisor	1	*Interviewer: Read list and circle all that apply.*		
	Peer/co-worker	2			
	Client	3			
	Community member	4			
	Other *(specify)*:	5			
	Other *(specify)*:	6			
3.2	Which of the following have you received from your **employer** for **doing your work well**?				
	Uniforms	1	*Interviewer: Read list and circle all that apply; more than one answer is allowed.*		
	Free/reduced price medicines and/or services	2			
	Equipment or supplies	3			
	Training courses	4			
	Other *(specify)*:	5			
	None	6			
3.3	Which of the following have you received as payment or gratuity from **clients**, the **relatives** of clients, or the **community** for doing your work well?				
	In-kind products or small gifts	1	*Interviewer: Read list and circle all that apply; more than one answer is allowed.*		
	Services in return	2			
	Money	3			
	Respect	4			
	Other *(specify)*:	5			
	None	6			
3.4	Are there opportunities for promotion if you do your job well?	Yes	No	Don't know	
		1	0	88	
3.5	Are there any job consequences if you do your work badly, in a way it should not be done?	1	0	88	**If No or DK, skip to Q. 4.0.**

continued

3. Motivation/Incentives (continued)

3.6	*If Yes*, what are the consequences and results?	*Interviewer: If response to item is yes, circle number and ask who administers it and circle number.*			
		Yes	Client	Community	Supervisor
	Verbal reprimand	1	1	2	3
	Loss of income	2	1	2	3
	Loss of time off	3	1	2	3
	Loss of clients	4	1	2	3
	Loss of responsibility	5	1	2	3
	Loss of job	6	1	2	3
	Shift to another ward/unit	7	1	2	3
	Other *(specify)*:	8	1	2	3
	Other *(specify)*:	9	1	2	3

4. Opinion/Feedback

Interviewer: Please read the following definition and examples of feedback to the respondent.

Feedback is information about how well or not so well you are doing the specific tasks of your job. Feedback is specific information and not general comments.

- *Positive feedback* tells you what you have been doing well in your job. For example, your supervisor tells you that you are doing a good job filling out clinic records: each client record is complete and accurate.
- *Constructive feedback* tells you how you can improve your work. For example, your supervisor tells you that if you were to greet clients by their name and with a smile, they would come to the health facility more often.

4.0	Have you ever received positive feedback from your supervisor?	Yes	No	Don't know	**If No or DK, skip to Q. 4.2.**
		1	0	88	
4.1	How many times in the last six months did you receive positive feedback from your supervisor?	Number of times			
4.2	Have you ever received feedback from your supervisor when he or she wasn't satisfied with some aspect of your work?	Yes	No	Don't know	**If No or DK, skip to Q. 4.4.**
		1	0	88	
4.3	How many times have you experienced something like this in the past 6 months?	Number of times			
4.4	Were you able to use this information in a way that helped you to do your job better?	Yes	No	Don't know	**If Yes, skip to Q. 5.0.**
		1	0	88	
4.5	*If No*, please explain why the information did not help you improve your work.				

5. Organizational Support

5.0a	Who do you go to when you have questions about an administrative task?		
	Visiting supervisor	1	*Interviewer: Do not prompt.*
	On-site supervisor	2	
	Peer/co-worker	3	
	Other *(specify)*:	4	
	No one	5	
5.0b	Who do you go to when you need medical supplies or medicines?		
	Visiting supervisor	1	*Interviewer: Do not prompt.*
	On-site supervisor	2	
	Peer/co-worker	3	
	Other *(specify)*:	4	
	Other *(specify)*:	5	
	No one	6	
5.1	Who do you go to when you have questions regarding a clinical task?		
	Visiting supervisor	1	*Interviewer: Do not prompt.*
	On-site supervisor	2	
	Peer/co-worker	3	
	Other *(specify)*:	4	
	Other *(specify)*:	5	
	No one	6	

5.2	Does this facility receive infrastructure, equipment, and/or supplies from outside sources, such as community, municipal government, associations?	Yes	No	Don't know	
		1	0	88	
5.3	Do clients have to bring their own supplies for the services they will receive (i.e., buy gloves)?	Yes	No	Don't know	
		1	0	88	
5.4	Do you receive regular reviews of your job performance from your supervisor at least once a year?	Yes	No	Don't know	**If No or DK, skip to Q. 5.7.**
		1	0	88	

5.5	How are the reviews conducted?		
	Verbally	1	*Interviewer: Read the list and select only one response.*
	In writing	2	
	Verbally *and* in writing	3	
	Don't know	4	

continued

5. Organizational Support (continued)

5.6	What is the purpose of the performance review?		
	To assess clinical skills	1	*Interviewer: Read the list and select only one response.*
	To assess administrative skills	2	
	To assess *both* clinical and administrative skills	3	
	Don't know	4	
5.7	How many times has an external supervisor come to this facility for the purpose of supervising you in the *past six months*?	Number of times	**If 0 times, skip to Q. 6.0.**
5.8	When the supervisor comes to supervise, what does he or she do?		
	Check supplies and medicines	1	*Interviewer: Read the list and circle all that apply; more than one response is allowed.*
	Perform administrative duties—i.e., review records, gather facility statistics (number of IUDs, number of vaccinations, number of deliveries, etc.)	2	
	Observe providers	3	
	Give consultations to clients	4	
	Other *(specify)*:	5	
5.9	On average, how long does the supervision visit take?	Duration of visit	
		_____ hours _____ minutes	

6. Environment and Equipment

6.0	In general, do you feel the physical environment is adequate for you to do your job well? For example:	Yes	No	Don't know	*Interviewer: Read all subquestions.*
	(a) Is there sufficient space?	1	0	88	
	(b) Do clients have privacy?	1	0	88	
	(c) Does the facility have electricity?	1	0	88	
	(d) Is the work place physically safe?	1	0	88	
6.1	Do you have the equipment, instruments, and supplies necessary to do your job well?	Yes	No	Don't know	**If Yes, skip to Q. 6.3.**
		1	0	88	
6.2	*If No*, what equipment, instruments, and supplies do you need?				
6.3	Do you believe the time given to do your tasks is practical and manageable?	Yes	No	Don't know	
		1	0	88	

continued

6. Environment and Equipment (continued)

6.4	Are you satisfied with the way the services provided in this facility are organized?	Yes	No	Don't know	**IF Yes, skip to Q. 7.0.**
		1	0	88	
6.5	*If No*, what changes would you introduce in your work environment and this facility?				

7. Knowledge and Skills

7.0	Have you received training in family planning and reproductive health in the past **five years**?	Yes	No	Don't know	**If No or DK, skip to Q. 7.4a.**
		1	0	88	
7.1	In what areas/procedures in family planning did you receive training? What did you learn in these courses? *Interviewer: After free-flow answer, probe as appropriate re: general family planning, family planning counseling, IUD insertion, infection prevention, female sterilization, vasectomy, and quality improvement (i.e., COPE®).* Any other areas?				
7.2	Have you been able to apply in your job what you learned in the training course?	Yes	No	Don't know	**If No, skip to Q. 7.3.**
		1	0	88	
	Interviewer: Probe which areas/procedures they have been able to use from their training. Specify comments from each course they took.				
7.3	*If No*, why not?				

7.4a	Do you have any of the following reference materials to assist you in your work? *If Yes*, can you show them to me?	Yes	No	Don't know	*Interviewer: Mark the materials you were shown.*
	Job aids/poster (*Interviewer: Give other examples, as appropriate.*)	1	0	88	Yes No
	Training materials	2	0	88	Yes No
	Technical manuals or guides (norms, protocols)	3	0	88	Yes No

continued

7. Knowledge and Skills (continued)

7.4b	*Interviewer: Probe which materials they have been able to use from their training. Specify comments regarding reference materials from each course they took.*				
7.5	Do you feel you have the knowledge or skills necessary to do your present job?	Yes	No	Don't know	**If Yes, skip to Q. 8.0.**
		1	0	88	
7.6	What knowledge and skills do you feel you still need in reproductive health and family planning?				

Section 2. Provider Attitudes and Practices

Interviewer—Say: "I would now like to ask you some questions about the family planning services you may provide."

8.0 Have you yourself counseled or provided information to women, couples, or men on contraceptives *in the last three months*?

1 = Yes 0 = No → **Go to Q. 8.2** 88 = Don't know

8.1 Which methods have you yourself discussed with women, couples, or men *in the last three months*?
Interviewer: Do not read list. Multiple responses are allowed. Choose response from list, if possible; if not listed, specify in other.

1 = Pill
2 = Injectable
3 = Condom
4 = IUD
5 = Female sterilization
6 = Vasectomy
7 = Lactational amenorrhea method (LAM)
8 = Natural family planning
9 = Other *(specify)* _____
10 = Other *(specify)* _____

8.2 Which of the following family planning methods have you actually provided to clients yourself *in the last three months*?
Interviewer: Read list and circle response for each.

1 = Pill
2 = Injectable
3 = Condom
4 = IUD
5 = Female sterilization
6 = Vasectomy
7 = Other *(specify)* _____
8 = Other *(specify)* _____

8.3 If a client would like a method or procedure that is not available at this facility, what would you say to her or him?
Interviewer: Do not read list. Multiple responses are allowed. Choose response from list, if possible; if not listed, specify in other.

1 = All methods or procedures are available
2 = Refer him or her to another facility
3 = Ask him or her to return when new stocks arrive
4 = Recommend another method or procedure
5 = Recommend another method while waiting for desired method
6 = Other *(specify)* _____
7 = Other *(specify)* _____
8 = Don't know

8.4 Are there any other methods you know about which you are not providing?
Interviewer—Probe: Do you know about Norplant implants? Vasectomy? Female sterilization?

8.5 In your professional opinion, what do you consider to be the necessary procedures (tests and exams) before you can offer the following methods?
Interviewer: Do not read the responses. Let the provider give the answers spontaneously. Ask: "Any other procedure?" Mark with ✓ in the appropriate boxes.

Test	Pill	Injectable	Condom	IUD	Female sterilization	Vasectomy
Medical history						
Physical exam						
Blood pressure						
Weight check						
Pelvic exam						
Breast exam						
Urine test						
Hemoglobin test						
STI screening						
Cervical smear						
Pregnancy test						
Other *(specify)*:						
Other *(specify)*:						
Other *(specify)*:						

*Interviewer: Read the following questions. Do **not** read the list of methods. For each question, probe: "Any other?"*

8.6 What methods would you recommend for most people who would like to *delay their first birth*?

8.7 What methods would you *not* recommend for most people who would like to delay their first birth?

8.8 What methods would you recommend for most people who would like to *space their next birth*?

8.9 What methods would you *not* recommend for most people who would like to space their next birth?

8.10 What methods would you recommend for most people who *desire no more children*?

8.11 What methods would you *not* recommend for most people who desire no more children?

8.12 What methods would you *never recommend* to anyone?

8.13–8.17

Interviewer: Read each question to the interviewee, and record the answers in the space provided. Record 77 = no specific criteria required; 88 = do not know; 99 = did not want to respond.

You may show this table to the interviewee for ease of completing the information in the table.

Method	8.13 What are the minimum and maximum age criteria for a client to use [name of method]? Min. age	8.13 Max. age	8.14 What is the minimum number of children a woman must have before using [name of method]? Number of children	8.15 When a woman is breastfeeding, can she use [name of method]? Mark with ✓	8.16 Can a woman use [name of method] immediately postpartum (0–48 hours after birth)? Mark with ✓	8.17 Can a woman use [name of method] immediately postabortion? Mark with ✓
Pill						
Depo-Provera						
Condom						
IUD						
Female sterilization						
Vasectomy						

8.18 Do you provide information and counseling on sexually transmitted infections (STIs) or HIV/AIDS to family planning clients?

1 = Yes 2 = No 88 = Don't know

8.19 Would you be willing to provide family planning services to an HIV-positive client?

1 = Yes 2 = No 88 = Don't know

8.20 Would you be willing to provide family planning services to a person living with AIDS?

1 = Yes 2 = No 88 = Don't know

Section 3. Method-Specific Knowledge

Interviewer—Say: "Now I would like to ask you a few questions about specific contraceptive methods."

1. IUD

9.0 When can an IUD be inserted?

Interviewer: Multiple responses are possible. Probe: "At any other times? What about after delivery? After abortion?"

	Mark with ✓
Any time it is certain that the woman is not pregnant	
Any time during the menstrual cycle	
Immediate postplacental (within 10 minutes)	
Within 48 hours of delivery	
After six weeks postpartum	
Immediately after abortion or miscarriage	
Other *(specify)*:	
Other *(specify)*:	
Don't know	

9.1 What problems, if any, may a client experience with an IUD?

Interviewer: Multiple responses are possible. Probe: "Any more?"

	Mark with ✓
No problems can arise	
Cramps	
Increased bleeding	
Spotting between menstrual periods	
Infection (PID)	
Backache	
Infertility	
Other *(specify)*:	
Other *(specify)*:	
Don't know any problems	

9.2 For which problems should she return to the clinic?

Interviewer: Multiple responses are possible. Probe: "Any more?"

	Mark with ✓
Cramps	
Increased bleeding	
Spotting between menstrual periods	
Infection (PID)	
Backache	
Infertility	
Other *(specify)*:	
Other *(specify)*:	
Don't know any problems	

9.3 When should she come back for a check-up after the insertion?

1 = No need to come back
2 = Within first three months
3 = Any other response
88 = Don't know

9.4 How many years can a woman keep an IUD once it has been inserted? _____ years

9.5 Does the IUD offer protection against STIs and HIV infection?

1 = Yes 0 = No 88 = Don't know

2. Injectables

9.6 When should a client start on injectables?

Interviewer: Multiple responses are possible. Probe: "Other?"

	Mark with ✓
Between first and fifth day of period	
Six weeks postpartum	
After menstruation	
Other *(specify)*:	
Other *(specify)*:	
Don't know	

9.7 When should a client return for the next injection?

1 = Three months for **Depo-Provera** 2 = Any other answer 88 = Don't know

9.8 What problems, if any, can a client experience with using injectable contraception?

Interviewer: Multiple responses are possible. Probe: "Other?"

	Mark with ✓
No problems can arise	
Nausea	
Mild headaches	
Irregular spotting/bleeding	
Slight weight gain	
Amenorrhea	
Infertility	
Other *(specify)*:	
Other *(specify)*:	
Don't know	

9.9 For which problems should she return to the clinic?

Interviewer: Multiple responses are possible. Probe: "Other?"

	Mark with ✓
Nausea	
Mild headaches	
Irregular spotting/bleeding	
Slight weight gain	
Amenorrhea	
Infertility	
Other *(specify)*:	
Other *(specify)*:	
Don't know	

9.10 Do injectables offer protection against transmission of STIs and HIV?

1 = Yes 0 = No 88 = Don't know

3. Sterilization (Male and Female)

9.11 In your program, which of the following conditions are considered an indication for sterilization (female and male)?

Interviewer: Read the list and mark the response. Multiple answers are allowed.

1 = Grand multiparity
2 = Repeat C-section (if mentioned, record number of C-sections: _____)
3 = Heart disease
4 = Hypertension
5 = HIV/AIDS
6 = Completed family size
7 = Client's request
8 = Other *(specify)* _____
9 = Other *(specify)* _____
88 = Don't know

9.12 In your program, which of the following techniques are used for sterilization (female and male)?

Interviewer: Read the list and mark the response. Multiple answers are allowed.

1 = Minilaparotomy
2 = Laparoscopy
3 = Laparotomy
4 = Subumbilical minilaparotomy
5 = Vasectomy
6 = No-scalpel vasectomy
7 = Other *(specify)* _____
8 = Other *(specify)* _____
9 = Not applicable
88 = Don't know

9.13 For couples interested in having no more children, is the sex of living children important for sterilization (female and/or male)?

1 = Yes 0 = No → **Go to Q. 9.15** 88 = Don't know

9.14 If so, what is the *minimum* number of boys and girls that couples should have before having a sterilization (female and/or male)?

Min. number of boys _____ Min. number of girls _____ 88 = Don't know

9.15 What information should women receive about female sterilization before agreeing to the procedure?

Interviewer: Do not read list. Circle all response(s) mentioned, and probe: "Any other?" Multiple answers are allowed. Please specify other responses mentioned.

1 = It is a permanent method (you will not be able to have children).
2 = It is a surgical procedure.
3 = You can change your mind before the procedure without any penalty.
4 = Temporary methods are available.
5 = There is a possibility of failure.
6 = Possible side effects
7 = Warning signs
8 = Causes familial problems.
9 = Causes post-sterilization syndrome.
10 = Causes bleeding problems.
11 = It is dangerous.
12 = Do not tell the client anything.
13 = Other *(specify)* _____
14 = Other *(specify)* _____
88 = Don't know

9.16 What information do you think men **should** receive about vasectomy before agreeing to the procedure?

Interviewer: Do not read list. Circle all response(s) mentioned, and probe: "Any other?" Multiple answers are allowed. Please specify other responses mentioned.

1 = It is a permanent method (you will not be able to have children).
2 = It is a surgical procedure.
3 = You can change your mind before the procedure without any penalty.
4 = Temporary methods are available.
5 = There is a possibility of failure.
6 = It is not castration.
7 = It does not affect your libido.
8 = It makes you fat.
9 = Possible side effects
10 = Warning signs
11 = Causes familial problems.
12 = Other *(specify)* _____
13 = Other *(specify)* _____
88 = Don't know

9.17 In your opinion, why aren't more women accepting female sterilization?

Interviewer: Do not read list. Circle all response(s) mentioned, and probe: "Any other?" Multiple answers are allowed. Please specify other responses mentioned.

1 = It is culturally unacceptable.
2 = Fear of surgery
3 = It is "Haram."
4 = Hospital stay
5 = Husband will divorce.
6 = Husband will remarry.
7 = Don't know it's available.
8 = Don't have interest.
9 = Other *(specify)* _____
10 = Other *(specify)* _____
88 = Don't know

9.18 In your opinion, why aren't more men accepting vasectomy?

Interviewer: Do not read list. Circle all response(s) mentioned, and probe: "Any other?" Multiple answers are allowed. Please specify other responses mentioned.

1 = It is culturally unacceptable.
2 = Fear of surgery
3 = It is "Haram."
4 = Hospital stay
5 = It is castration.
6 = It makes you fat.
7 = It decreases libido.
8 = Don't know it's available.
9 = Don't have interest.
10 = Other *(specify)* _____
11 = Other *(specify)* _____
88 = Don't know

9.19 In your opinion, do physicians face institutional/clinical barriers while offering sterilization (voluntary surgical sterilization) in Guinea?

1 = Yes 0 = No → **Go to Q. 9.21a** 88 = Don't know

9.20 *If Yes*, what are some of these institutional barriers?

Interviewer: Do not read list. Circle all response(s) mentioned, and probe: "Any other?" Multiple answers are allowed. Please specify other responses mentioned.

1 = Equipment unavailable
2 = Service provider knowledge
3 = No counseling for those methods at the site
4 = Cost
5 = Not a priority
6 = Provider prejudice that clients won't accept method
7 = Other *(specify)* _____
8 = Other *(specify)* _____
88 = Don't know

9.21a Is there a need for a female sterilization client to come back to the clinic after the operation?

1 = Yes 0 = No → **Go to Q. 9.22** 88 = Don't know → **Go to Q. 9.22**

9.21b *If Yes*, when should she return? _____

9.22 After the sterilization operation, what are the problems, if any, that a woman may experience with sterilization?

Interviewer: Multiple responses are possible. Probe: "Other?"

	Mark with ✓
No problems can arise	
Serious bleeding	
Pain at the incision site	
Infection	
If the woman gets pregnant, pregnancy may occur outside the womb (ectopic pregnancy)	
Severe pain in the lower belly	
Other *(specify)*:	
Other *(specify)*:	
Don't know	

9.23 For which problems should she return to the clinic?

Interviewer: Multiple responses are possible. Probe: "Other?"

	Mark with ✓
Serious bleeding	
Pain at the incision site	
Infection	
If the woman gets pregnant, pregnancy may occur outside the womb (ectopic pregnancy)	
Severe pain in the lower belly	
Other *(specify)*:	
Other *(specify)*:	
Don't know	

9.24 Does female sterilization offer protection against STIs and HIV infection?

1 = Yes 0 = No 88 = Don't know

9.25 How long after a vasectomy does the man need to continue using another family planning method?

1 = 20 ejaculations 2 = 12 weeks 3 = Other answer 88 = Don't know

9.26 After the vasectomy, what problems, if any, may a man experience?

Interviewer: Multiple responses are possible. Probe: "Other?"

	Mark with ✓
No problems can arise	
Discomfort shortly after the procedure	
Slight swelling of the scrotum	
Bleeding/clots at the incision site	
Infection soon after the procedure	
Other *(specify)*:	
Other *(specify)*:	
Don't know	

9.27 For which problems should he return to the clinic?

Interviewer: Multiple responses are possible. Probe: "Other?"

	Mark with ✓
Discomfort shortly after the procedure	
Slight swelling of the scrotum	
Bleeding/clots at the incision site	
Infection soon after the procedure	
Other *(specify)*:	
Other *(specify)*:	
Don't know	

9.28 Are condoms routinely provided to vasectomy clients after the operation?

1 = Yes 0 = No 88 = Don't know

9.29 Does vasectomy offer protection against STIs and HIV infection?

1 = Yes 0 = No 88 = Don't know

Section 4. Values

10.0 *Interviewer—Say: "We are almost finished. In this last section, I am going to ask you what you think about specific family planning methods. Please tell me your opinon/what you believe regarding the method."*

Q.	Method	Opinion
10.1	Pill	
10.2	Depo-Provera	
10.3	Condoms	
10.4	IUD	
10.5	Female sterilization	
10.6	Vasectomy	

Thank you very much for answering these questions. We appreciate your time and honesty.

Note to interviewer: Please be sure to return to **page 1** and indicate whether the survey was completed or not completed. Be sure you sign the survey and complete all background information on page 1.

Client Exit Interview

General Information

Facility visited (name): _____

City/town (name): _____

Region: _____

Date of clinic visit (dd/mm/yy): ____/____/____

Name of observer: _____

Instructions to the interviewer: The clients should be interviewed individually and in private. It should be made clear that you are seeking their assistance in finding ways of improving the functioning and quality of the services offered by clinics in general, and are not evaluating the performance of the clinic. The client's consent to give an interview must be requested.

Read this greeting and confidentiality pledge:

"Hello. We would like to improve the services provided by the facility and would beinterested in finding out about your experience today. I would like to ask you some questions about your visit at the health facility and would appreciate it if you could spend some time answering some questions. I will not write down your name, and everything you say will be kept strictly confidential. The information gathered will be stored in our office files and will not be shared with other people. Your participation will not affect your assistance at this health facility. You are not obligated to answer any question you don't want to, and you may withdraw from the interview at any time. Do I have your permission to continue?"

- If the client agrees to continue, ask if she has any questions. Respond to questions as appropriate, and then begin by asking Q. 1.
- **If the client does not agree to continue, thank her and go to the next interview.**

Client Background

1. What was the reason for your visit today?
   1 = Family planning
   2 = Antenatal care
   3 = Well-baby care (pediatrics, immunizations)
   4 = Gynecological services
   5 = STI/HIV
   6 = Other *(specify)* _____

   _____

Now I would like to begin by asking you a few questions about yourself and your family:

2. What is your marital status?
   1 = Married
   2 = Divorced/separated/widowed
   3 = Single

3. How old are you?

   _____ Years _____ Don't know

4a. Have you ever been pregnant?

   1 = Yes 0 = No → **Go to Q. 6a** 88 = Don't know

4b. How many pregnancies have you had? _____

5a. How many living children do you have? _____
   If number of living children is *same* as number of pregnancies (Q. 4b), skip to Q. 6d. If number of living children is *less* than number of pregnancies (Q. 4b), go to Q. 5b.

5b. Have you ever had a miscarriage, abortion, or stillbirth?

   1 = Yes 0 = No → **Go to Q. 6d** 88 = Don't know → **Go to Q. 6d**

5c. *If Yes*, how many miscarriages? _____ How many abortions? _____ How many stillbirths? _____

6a. Do you want to have any children/any more children?

   1 = Yes 0 = No → **Go to Q. 6d** 88 = Don't know → **Go to Q. 6d**

6b. *If Yes*, how many? _____

6c. When? _____

6d. What is the highest level of school you have completed?
   0 = No schooling
   1 = Primary
   2 = Secondary
   3 = Postsecondary
   4 = Academy/university
   88 = Don't know

Family Planning Practices

7. Have you ever used a contraceptive method?

   1 = Yes 0 = No → **Go to Q. 9** 88 = Don't know → **Go to Q. 9**

8. *If Yes*, which method(s)? *(Do not read the list. Circle all methods mentioned.)*

1 = Pill	7 = Vasectomy
2 = Depo-Provera	8 = Withdrawal
3 = Condom	9 = Rhythm
4 = Vaginal methods	10 = Other *(specify)* _____
5 = IUD	77 = Not applicable
6 = Female sterilization	88 = Don't know

9. I will now mention different family planning methods and would like you to tell me what you understand about each method. If you do not know what it is, say "I don't know." Then I will ask you in general if you approve or disapprove of couples using these methods to space or avoid pregnancy and why.

Interviewer: Keep asking "Any more reasons why you approve or disapprove?" until she has no more.

Method	Definition of method	Approve/disapprove (A or D)	Reason for Approval/disapproval
Pill			
Depo-Provera			
Condom			
Vaginal methods (i.e., spermicides)			
IUD			
Female sterilization			
Vasectomy			
Withdrawal			
Rhythm			
Other *(specify)*:			

10. Did you receive any information or did anyone talk to you about family planning methods during your visit?

    1 = Yes 0 = No 88 = Don't know

11. Were you given any brochure or educational material to take home?

    1 = Yes *(specify content)* _____ 0 = No 88 = Don't know

12. Did you attend a group education session on family planning today?

    1 = Yes 0 = No 88 = Don't know

13. Did you receive any information about these methods during this or previous visits? *(Read the list.)*

Method	Yes	No
Pill		
Depo-Provera		
Condom		
Vaginal methods (i.e., spermicides)		
IUD		
Female sterilization		
Vasectomy		
Withdrawal		
Rhythm		
Other *(specify)*:		

14. Would you ever consider getting a sterilization?

    1 = Yes 0 = No 88 = Don't know 99 = Didn't want to respond

15. Would your partner ever consider getting a sterilization?

    1 = Yes 0 = No 77 = Not applicable 88 = Don't know 99 = Didn't want to respond

Interviewer: Apply questions 16–19 only to women who have come for antenatal or postpartum care (see response to Q. 1). If a woman did not come for antenatal or postpartum care, skip to Q. 20.

16. Do you plan to use a family planning method after your baby is born?

    1 = Yes 0 = No → **Go to Q. 19** 88 = Don't know → **Go to Q. 19**

17. How soon do you plan to begin using a method after delivery?

    1 = Immediately after delivery
    2 = Within six weeks
    3 = Within six months
    4 = Within a year
    5 = Other *(specify)* _____
    77 = Not applicable
    88 = Not sure/don't know

18. Which method do you plan to use? (*Do not read the list.*)

1 = Pill
2 = Depo-Provera
3 = Condom
4 = Vaginal methods
5 = IUD
6 = Female sterilization
7 = Vasectomy
8 = Withdrawal
9 = Rhythm
10 = Other *(specify)* _____
77 = Not applicable
88 = Don't know

All answers go to Q. 20

19. If you do not plan to use a contraceptive method after your baby is born, can you tell me the *primary* reason? *(Do not read the list. Circle **one** reason only.)*

1 = Health reasons
2 = Breastfeeding
3 = Still unsure
4 = Method not available
5 = Prefer to wait until later
6 = Don't believe that I'll be at risk for a pregnancy soon
7 = Against my religion
8 = Partner/family does not approve
9 = Other *(specify)* _____
77 = Not applicable
88 = Don't know

Client Satisfaction

20. Do you feel that today you received the information and services you wanted?

1 = Yes 0 = No 2 = Some but not enough 88 = Don't know

21. Do you feel that your consultation with the clinic staff was too short, about the right length of time, or too long?

1 = Too short 2 = About right 3 = Too long 88 = Don't know

22. Do you think that the staff at this clinic are skillful?

1 = Yes 0 = No 88 = Don't know 99 = Didn't want to respond

23. During this visit did you have any questions you wanted to ask?

1 = Yes 0 = No → **Go to Q. 26**

24. *If Yes*, did the provider let you ask the questions?

1 = Yes 0 = No → **Go to Q. 26**

25. *If Yes*, did the provider respond to your questions to your satisfaction?

1 = Yes 0 = No 2 = Partially 88 = Don't know

26. In your opinion, did you have enough privacy during your consultation with the service provider?

1 = Yes 0 = No *(specify why not)* _____

27. During the consultation, did you feel that the provider was easy to understand when he or she explained things, or was he or she difficult to understand?

    1 = Easy to understand 2 = Difficult to understand 88 = Don't know

28. During the consultation, did you feel that the clinic staff were friendly?

    1 = Yes 0 = No 2 = Partially 88 = Don't know 99 = Didn't want to respond

29. Are there areas of this health facility that you think need improvement, to make them cleaner, more comfortable, or more private?

    1 = Yes 0 = No → **Go to Q. 31**

30. *If Yes*, please tell me which ones and why.

    _____

    _____

    _____

    _____

31. For your visit today, did you have an appointment at a specific time?

    1 = Yes 0 = No 88 = Don't know

32. About how long did you wait between the time you first arrived at this clinic and the time you were seen?

    1 = No wait → **Go to Q. 34**
    2 = Less than one-half hour
    3 = One-half hour to less than one hour
    4 = One hour to fewer than two hours
    5 = Two hours or more
    88 = Don't know

33. Do you feel that your waiting time was reasonable, or too long?

    1 = Reasonable 2 = Too long 88 = Don't know

34. If a friend of yours wanted family planning services, where would you recommend her to go?

    1 = Come to this facility → **Go to Q. 36**
    2 = Go somewhere else
    3 = Other *(specify)* _____
    88 = Don't know

35. Why would you encourage her to go to somewhere else? *(Circle the most important reason.)*

    1 = More convenient, closer
    2 = Better quality service
    3 = Wider range of services
    4 = To be more anonymous
    5 = Services cheaper
    6 = Likes/trusts provider in the other place
    7 = Other *(specify)* _____
    88 = Don't know
    99 = Didn't want to respond

36. Apart from this clinic, do you know of any other place near your home where you can get _____ _____ services?

(Interviewer: Refer to Q. 1 to ask regarding specific type of service.)

1 = Yes 0 = No → **Go to Q. 37b** 88 = Don't know → **Go to Q. 37b**

37a. *If Yes*, what was the main reason you came to this clinic instead of the other place?

(Interviewer: Probe for the main reason; circle one answer only.)

1 = Used to coming to this facility
2 = More convenient, closer
3 = Better quality service
4 = Wider range of services
5 = Services cheaper
6 = Likes/trusts provider here
7 = Other *(specify)* _____
8 = I was referred
88 = Don't know
99 = Didn't want to respond

Interviewer: If the reason for the client's visit was family planning (refer to Q. 1), go to Q. 38.

37b. Apart from this clinic, do you know of any other place near your home where you can get family planning services?

1 = Yes 0 = No 88 = Don't know

38. Overall, how satisfied are you with the visit to the clinic?

1 = Very satisfied 2 = Satisfied 3 = Somewhat satisfied 4 = Unsatisfied

39. Was a date given for your next appointment?

1 = Yes 0 = No 88 = Don't know

40. Do you have any suggestions for improving the services provided by this facility?

_____

_____

Thank the client for her time.

Observation Guide

General Information

Health facility (name): _____

Type of facility:
___ Regional hospital ___ District hospital ___ Health center ___ Maternity clinic ___ NGO clinic

Region: _____

Date (dd/mm/yy): ____/____/____ Start time: _____ a.m./p.m.

Name of observer: _____

Instructions to the observer: Start your observation when the provider establishes contact with the client. Observe the provider's performance and check, as appropriate, each item. Write specific comments when the provider does not perform according to norms (e.g., when you check "no").

The Provider

	Yes	No	Comments
1. Greets the client, making sure that she is comfortable and has the needed privacy			
2. Asks questions, allows the client to talk, and encourages the client to ask questions			
3. Asks the client about her reproductive health and FP intentions and if he or she has any preferences			
4. Provides information about the client's selected method and, if the client does not have any preference or changes her opinion, offers information about other methods			
5. Explains advantages and disadvantages of the selected method, including its side effects			
6. Informs about and discusses warning signs and what to do in case they appear			
7. Uses clear and simple language, making sure the client has understood			
8. Clarifies any doubts or misconceptions about the methods, as appropriate			
9. Explains the need to prevent STIs/HIV and encourages the use of dual protection, if/when needed			

continued

The Provider (continued)

	Yes	No	Comments
10. Provides the client with written information/ instructions or brochures about the selected method			
11. Provides the client with enough supplies of the selected method (if pills, condoms)			
12. Performs appropriate screening (medical history, physical exam), according to selected method			

Observation of the Provision of Temporary Methods

	Yes	No	Comments
Infection Prevention			
13. The provider washes his or her hands before and after examining the client or doing any procedure.			
14. The exam/procedure area/room is clean.			
15. Decontamination and cleaning of used instruments are done properly.			
16. Clinic wastes and used sharps and needles are disposed of properly.			
Interval IUD			
17. Insertion, aseptic technique was followed.			
18. Bimanual and speculum exam were done before insertion.			
19. The uterus was sounded.			
20. A tenaculum was used.			
21. The no-touch technique was used for preparation of the IUD for insertion and during insertion.			
22. Removal was done without difficulty.			
Injectables			
23. Injection technique is adequate.			
24. The needle was disposed of properly.			
25. The same type of injectable is used consistently.			

Observations of the Provision of Permanent Methods

	Yes	No	Comments
Female Sterilization			
26. Informed consent is documented.			
27. Preoperative procedures (e.g., physical examination) are completed appropriately.			
28. The anesthesia regimen is appropriate (e.g., client is comfortable, without pain).			
29. A uterine elevator is used.			
30. The abdomen is approached uneventfully.			
31. The tubal hook is used correctly and appropriately (if used at all).			
32. Handling during surgery is gentle.			
33. The tubes are accessed easily.			
34. Tubal occlusion is done appropriately.			
35. The abdomen is closed appropriately.			
36. Vital signs are monitored during surgery.			
37. The client is monitored in the recovery room.			

Emergency Preparedness

	Yes	No	Comments
38. Emergency equipment is operating satisfactorily.			
39. Staff are knowledgeable about emergency drugs.			

Site Assessment and Service Statistics Guide

General Information

Facility visited (name): _____

City/town (name): _____

Region: _____

Date of clinic visit (dd/mm/yy): ____/____/____

Name of observer: _____

Instructions to the data collector: This inventory should be completed by observing the facilities that are available and through discussions with the person in charge of family planning on the day of the visit. *In all cases,* you should verify that the items exist by actually seeing them yourself. If you are not able to see them, then code this accordingly. Remember that the objective is to identify the equipment and facilities that currently exist, not to evaluate the performance of the staff or clinic.

For each item, circle the response or describe, as appropriate.

Accessibility

1. What is the official opening time for this facility? _____ a.m./p.m.

2. How soon after the official opening time were services provided?
   1 = Immediately (as soon as facility officially opened)
   2 = Within first 30 minutes
   3 = Within 30 to 60 minutes
   4 = More than 1 hour
   7 = Not applicable

3. What is the official closing time for this facility? _____ a.m./p.m.

4. How many days per week are family planning services offered at this facility? _____ days/week

5. Is there a sign announcing that family planning services are available?
   1 = Outside the facility
   2 = Inside the facility
   3 = Both inside and outside the facility
   4 = No sign visible

Infrastructure

6. *On the day of the visit,* does the facility have the following?

Facility infrastructure	Circle Y or N	
1. Source of clean water	Y	N
2. Source of electricity	Y	N
3. A waiting room/area for clients	Y	N
4. Working toilets available for clients	Y	N
5. Examination room (common)	Y	N
6. Examination room (separate)	Y	N
7. Counseling room (walls and a door)	Y	N
8. Counseling area	Y	N
9. Laboratory area	Y	N
10. Operation room with air conditioner	Y	N
11. Instrument sterilization room	Y	N
12. Scrub area	Y	N
13. Storage area	Y	N
14. Postoperative rest area/room	Y	N
15. Hospitalization ward	Y	N
16. Utility room for soiled linens	Y	N

Staffing

7. Indicate the number of staff who provide family planning at this facility within each designation.

Designation	No. of staff assigned	No. of staff on duty today
1. Specialist (ob/gyn)	_____	_____
2. Specialist (other) *(specify)* _____	_____	_____
3. General practitioner	_____	_____
4. Nurse	_____	_____
5. Midwife	_____	_____
6. Assistant nurse	_____	_____
7. Medical student/intern	_____	_____
8. Other medical staff *(specify)* _____	_____	_____

IEC Materials and Activities

8. Which FP IEC materials are available?

Type of material	Circle Y or N	
1. FP posters on walls	Y	N
2. Flipchart	Y	N
3. FP brochure/pamphlet for clients	Y	N
4. FP user instructions	Y	N
5. Samples of contraceptives	Y	N
6. Anatomical models	Y	N
7. Method-specific IEC materials	Y	N
If Yes, specify _____		

9. Are "health talks" (group lectures or discussions with clients) held in this facility?

   1 = Yes 0 = No → **Go to Q. 11** 88 = Don't know → **Go to Q. 11**

10. If Yes, do they include family planning?

    1 = Yes 0 = No 88 = Don't know

Medical Examination Facilities

11. Are the following conditions maintained in the examination area?

Examination area conditions	Circle Y or N	
1. Auditory privacy	Y	N
2. Visual privacy	Y	N
3. Cleanliness*	Y	N
4. Adequate light source**	Y	N
5. Adequate water***	Y	N

* "Cleanliness" means floors swept and mopped at start of the day, with no dust on window sills or tables.
** "Adequate light" means functioning electric light or sufficient natural light to perform necessary tasks.
*** "Adequate water" means a sufficient quantity of clean water for washing hands and equipment.

Equipment and Commodities Inventory

12. How many of each of the following types of FP equipment are available in the facility and stockroom? *Write '0' if none are available or if those available are not in working order.*

Type of equipment	No. in working order for family planning use
1. Sterilizing apparatus	_____
2. Examination table	_____
3. Flashlight and/or angle-poise lamp	_____
4. Blood pressure apparatus	_____
5. Stethoscopes	_____
6. Thermometer	_____
7. Adult weighing scale	_____
8. Microscope	_____
9. Specula	_____
10. Tenacula	_____
11. Uterine sounds	_____
12. Sponge/ring forceps	_____
13. Scissors	_____
14. Minilaparotomy kits	_____
15. No-scalpel vasectomy kits	_____
16. Adjustable operating table	_____
17. Operating lamp	_____
18. Inhalation anesthesia machine	_____
19. Emergency management equipment and supplies	_____
20. Container for disposing of needles/syringe	_____

Expendable Supplies

13. Has the facility experienced stock outs of the following equipment/supplies within the past three months?

Equipment/supplies	Circle Y or N	
1. Gloves	Y	N
2. Disinfectant solutions	Y	N
3. Syringes	Y	N
4. Suture material	Y	N
5. Anesthetic drugs	Y	N
6. Other *(specify)* _____	Y	N
7. Other *(specify)* _____	Y	N
8. Other *(specify)* _____	Y	N

14. Record below whether the facility provides each of the following methods.

Type of contraceptive	Circle Y or N	
1. Combined pills	Y	N
2. Progestin-only pills	Y	N
3. Injectables	Y	N
4. Condoms	Y	N
5. IUD	Y	N
6. Female sterilization	Y	N
7. Vasectomy	Y	N

15. Ask: In the last six months, which contraceptives have ever been out of stock?

Type of contraceptive	Check (✓) if out of stock in last six months
1. Combined pills	_____
2. Progestin-only pills	_____
3. Injectables	_____
4. Condoms	_____
5. IUD	_____

16. How many packets of pills does each client receive per visit? _____ packets

17. How many condoms does each client receive per visit? _____ condoms

18. Is there a record system for keeping track of family planning commodities received and dispersed?

    1 = Yes 0 = No

19. Are family planning commodities stored according to their expiration date?

    1 = Yes 0 = No

20. If there are expired commodities, are they stored separately?

    1 = Yes 0 = No 77 = Not applicable

21. Are storage facilities for contraceptives adequate?
    ("Adequate" means not exposed to rain and sun, protected from rats and pests, and not subjected to extreme heat. All criteria must be met to answer Yes.)

    1 = Yes 0 = No

Record Keeping and Reporting

22. Is there a daily family planning activity register or log book?

    1 = Yes 0 = No

23. Is there a client record card for recording multiple visits, or is a new card issued for each visit?
    1 = No cards
    2 = Multiple visit card
    3 = New card issued for each visit
    77 = Not applicable

24. In what condition is the record-card system?
    1 = Well organized
    2 = Partially organized, still usable
    3 = Disorganized, unusable
    77 = Not applicable

25. Are monthly statistical reports about family planning activities sent to a supervisor or higher unit?
    1 = Yes 0 = No → **Go to Q. 28**

26. *If Yes*, when was the last report sent?
    Month/Year _____ /_____ 77 = Not applicable 88 = Don't know

27. *If Yes*, is feedback received on reports?
    1 = Yes 0 = No 2 = Irregularly 77 = Not applicable

28. Are the following services available in this clinic?

Services provided	Circle Y or N	
1. Essential obstetric care*	Y	N
2. Emergency obstetric care**	Y	N
3. Antenatal care	Y	N
4. Postpartum care	Y	N
5. Postabortion care	Y	N
6. Voluntary counseling and testing for HIV/AIDS	Y	N
7. Consultations for STIs	Y	N
8. Well infant/child care	Y	N
9. Immunization	Y	N
10. Oral rehydration therapy	Y	N
11. Consultations for infertility	Y	N
12. Curative services	Y	N
13. FP counseling	Y	N

* Essential obstetric care is antenatal care, delivery, and manual removal of the placenta.
** Emergency obstetric care is essential care plus cesarean section, blood transfusion, and anesthesia.

Service Statistics

29. Compile the statistics for the following table, wherever possible using a period of six consecutive calendar months from July 2003 to December 2003. In those cases where data for a specific calendar month period are not available, use data from a month immediately prior to July 2003 and note the month for which you are registering data.

    For each method, indicate the number of new and repeat clients and the number of contraceptives issued or procedures done (in the case of sterilizations). If the log book does not differentiate between "new" and "repeat" clients and only lists the total number of clients, then make a note on the form stating this.

    Mark "0" where there are no clients or methods issued.

    Code "77777" if a method is not provided at this facility; Code "99999" if no statistics are available.

	Method							
	Combined pill	Progestin-only pill	Injectables	Condom	IUD	Female sterilization	Vasectomy	Total
July 2003								
New								
Repeat								
No. issued								
August 2003								
New								
Repeat								
No. issued								
September 2003								
New								
Repeat								
No. issued								
October 2003								
New								
Repeat								
No. issued								
November 2003								
New								
Repeat								
No. issued								
December 2003								
New								
Repeat								
No. issued								

Thank individual(s) for taking the time to answer these questions.

Client Record-Review Checklist for Family Planning Services

Site: _____ Date: _____

Reviewer: _____

(Select 10 records at random)

Checklist Item	1	2	3	4	5	6	7	8	9	10	Total
1. Client identification information recorded											
2. Date of visit recorded											
3. Client's reason for visit recorded											
4. Medical history recorded											
5. Reproductive health history recorded											
6. General physical examination conducted											
7. Client's signs and symptoms recorded											
8. Information about provision of the FP method											
9. Any prescriptions or treatment recorded											
10. Follow-up plans recorded											
11. If follow-up visits recorded, include information on side effects complaints and management											
12. Entries are legible											

Comments on records reviewed: _____

_____

_____

_____

_____

_____

_____

_____